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

BOLIVIA

PROJECT PAPER

REPRODUCTIVE HEALTH SERVICES

AID/LAC/P-540

Project Number: 511-0568

AGENCY FOR INTERNATIONAL DEVELOPMENT

PROJECT DATA SHEET

1. TRANSACTION CODE: [X] A = Add, C = Change, D = Delete — Amendment Number: _____ — DOCUMENT CODE: 3

2. COUNTRY/ENTITY: BOLIVIA

3. PROJECT NUMBER: 511-0568

4. BUREAU/OFFICE: L A C [05]

5. PROJECT TITLE (maximum 40 characters): REPRODUCTIVE HEALTH SERVICES

6. PROJECT ASSISTANCE COMPLETION DATE (PACD): MM 09 DD 30 YY 95

7. ESTIMATED DATE OF OBLIGATION (Under "B." below, enter 1, 2, 3, or 4): A. Initial FY 90 B. Quarter 4 C. Final FY 94

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

A. FUNDING SOURCE	FIRST FY 90 B. FX	C. L/C	D. Total	LIFE OF PROJECT E. FX	F. L/C	G. Total
AID Appropriated Total	2,000	450	2,450	7,928	1,372	9,300
(Grant)	(2,000)	(450)	(2,450)	(7,928)	(1,372)	(9,300)
(Loan)	(0)	(0)	(0)	(0)	(0)	(0)
Other U.S. 1.						
Other U.S. 2.						
Host Country		300	300		1,348	1,348
Other Donor(s)						
TOTALS	2,000	750	2,750	7,928	2,720	10,648

9. SCHEDULE OF AID FUNDING ($000)

A. APPROPRIATION	B. PRIMARY PURPOSE CODE	C. PRIMARY TECH. CODE 1. Grant	2. Loan	D. OBLIGATIONS TO DATE 1. Grant	2. Loan	E. AMOUNT APPROVED THIS ACTION 1. Grant	2. Loan	F. LIFE OF PROJECT 1. Grant	2. Loan
(1) GS	510	510				1,000		2,000	
(2) PH	440	440				1,450		7,300	
(3)									
(4)									
TOTALS						2,450 *		9,300	

10. SECONDARY TECHNICAL CODES (maximum 6 codes of 3 positions each): 410 450

11. SECONDARY PURPOSE CODE: 480

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

A. Code	BU	BR	PVOU	PVON			
B. Amount							

13. PROJECT PURPOSE (maximum 480 characters)

To improve access and quality of reproductive health services.

*includes two FY90 OYB transfers to AID/W (see Table 5), totalling $ 175,000. Therefore, the FY90 balance is $ 2,275,000.

14. SCHEDULED EVALUATIONS: Interim MM YY MM YY; Final MM 08 YY 94

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

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

The USAID Controller has reviewed the financial procedures described herein and hereby indicates his concurrence.

GUILLERMO DENARANDA
ACTING CONTROLLER

17. APPROVED BY — Signature: _____ Title: G. REGINALD VAN RAALTE, MISSION DIRECTOR — Date Signed: MM 07 DD 16 YY 90

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

AID 1350-4 (8-79)

PROJECT AUTHORIZATION

Name of Country: BOLIVIA

Name of Project: Reproductive Health Services

Number of Project: 511-0568

1. Pursuant to Section 104 of the Foreign Assistance Act of 1961, as amended, I hereby authorize the Reproductive Health Services Project (the "Project") for the Republic of Bolivia (the "Cooperating Country") and Non-Governmental Organizations in Bolivia ("NGOs") involving planned obligations of not to exceed Nine Million Three Hundred Thousand United States Dollars ($9,300,000) in grant funds (the "Grant") over a five-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 approximately five years, from date of initial obligation until September 30, 1995.

2. The Project will improve the access and quality of reproductive health (family planning) services by supporting both government and NGO reproductive health programs through information, education and communication services, community-based reproductive health services, training, local-level grants, commodities, research, social marketing, and other related components.

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

4. a. Source and Origin of Commodities, Nationality of Services

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

b. Covenants Regarding Family Planning Services

(1) None of the funds provided under the Grant, or goods or services financed thereby, may be used for or in support of a program that includes involuntary sterilization as a method of family planning, or to coerce or provide any financial incentive to any person to undergo sterilization.

(2) None of the funds provided under the Grant, or goods or services financed thereby, may be used for the performance of abortions as a method of family planning or to motivate or coerce any person to practice abortions, or 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.

(3) All funds authorized for this Project shall be used in accordance with current U.S. legislation and A.I.D. policy governing the provision of population assistance.

G. Reginald van Raalte
Director
USAID/Bolivia

7/6/90
Date

CLEARANCES:

A/HHR:SAnderson — Date 6/25/90
A/DP:SAranibar — Date 6/29/90
PD&I:JJCloutier — Date 6/27/90
A/CONT:GPeñaranda — Date 7/6/90
A/DD: JDavison — Date 7/6/90

Drafted by:SCAllen:RLA 6/25/90

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ANNEXES

GLOSSARY

AID/W	-	Agency for International Development/Washington
BAT	-	Budget Allowance Transfer
CAs	-	Cooperating Agencies
CIES	-	Center for Research, Education & Services
CIS	-	Center for Social Research
COBREHS	-	Consultora Boliviana de Reproducción Humana y Salud
COF	-	Center for Family Orientation
CONAPO	-	National Population Council
CROF	-	Radio Clinic for Family Orientation
DAI/PAC IIB	-	Development Associates Inc./Family Planning Training for Paramedical, Auxiliary and Community Personnel IIB
DHS	-	Demographic and Health Survey
EOPS	-	End of Project Status
ESF	-	Economic Support Funds
FAMES	-	Foundation for Medical-Social Assistance
FEPADE	-	Ecumenical Foundation for Development
FSG		San Gabriel Foundation
GOB	-	Government of Bolivia
IBSS/CNS		Bolivian Institute of Social Security/Caja Nacional de Salud
IEC	-	Information, Education and Communication
INE	-	National Institute of Statistics
IPPF		International Planned Parenthood Federation
IRD	-	Institute for Resource Development (Macro Systems)
JHPIEGO	-	Johns Hopkins Program for International Education in Gynecology and Obstetrics
JHU/PCS	-	Johns Hopkins University/Population Communications Service
JSI	-	John Snow Inc.
MIS	-	Management Information Systems
MOH/MC	-	Ministry of Health/Maternal-Child Health Division
MOP	-	Ministry of Planning and Coordination

MSH/FPMT	-	Management Sciences for Health/Family Planning Management Training
MOV	-	Means of Verification
NCC	-	National Coordinating Committee
NFP	-	Natural Family Planning
NGOS	-	Non-Governmental Organizations
OR	-	Operations Research
OVI	-	Objectively Verifiable Indicators
OYB	-	Operating Year Budget
PAHO	-	Pan American Health Organization
PGA	-	Project Grant Agreement
PRONIMA	-	Proyecto Niño-Madre (UNFPA/PAHO)
PROSALUD	-	Self-Financing Primary Health Care/Santa Cruz
PVOs	-	Private Voluntary Organizations
S&T/H	-	Science and Technology Bureau/Office of Health
S&T/POP	-	Science and Technology Bureau/Office of Population
S&T/POP/CPSD	-	Science and Technology Bureau/Office of Population/ Commodity Procurement and Support Division
SBGO	-	Bolivian OB/GYN Society
SERVIFAM	-	Complete Family Services, (Cochabamba)
SMC	-	Social Marketing
SNV	-	Dutch Service for Technical and Social Cooperation
STDS	-	Sexually-Transmitted Diseases
TA	-	Technical Assistance
TFG (SOMARC)	-	The Future Group/Social Marketing for Change
TFG/DGI	-	The Futures Group/Development Group Inc.
TFG/RTI	-	The Futures Group/Research Triangle Inc.
UNFPA	-	United Nations Fund for Population Activities
UNICEF	-	United Nations Children's Fund
USAID/B	-	United States Agency for International Development/Bolivia
USG	-	United States Government

I. RECOMMENDATION AND PROJECT SUMMARY

SUMMARY RECOMMENDATION

USAID recommends that the Reproductive Health Services Project be approved on grant terms at a total five year dollar funding level of $9.3 million. The Project will support reproductive health services (family planning and related child survival activities) of the Government of Bolivia (GOB) and several private Non-Governmental Organizations (NGO), most of which A.I.D. already supports in Bolivia. The components of the Project are: (1) support for GOB reproductive health activities, (2) NGO reproductive health activities, and (3) social marketing of contraceptives. Funds for the GOB ($1.1 million) will be obligated in a Project Grant Agreement (PGA) in FY 90. Funds for NGO activities and social marketing will be obligated by buy-ins and add-ons to existing AID/W central cooperative agreements and contracts with U.S. cooperating agencies, universities, and firms with established reputations in family planning and child survival. The GOB will contribute $1,348,000 in local currency to the Project, $360,000 of which will be drawn from Economic Support Fund (ESF) local currency accounts. Coordination among public and private institutions involved in the Project will be assured by a National Coordinating Committee (NCC) for the Project, which is already functioning, chaired by the Executive Secretary of the GOB National Population Council (CONAPO).

An FS-1 direct hire BS-50, a Bolivian professional PSC, and a Bolivian PSC secretary will manage the Project for USAID/B, within the Office of Health and Human Resources. Funds are budgeted for audit, evaluation, and project-related logistical support. Contraceptive commodities (condoms, pills, and IUDs) will be procured centrally through S&T/POP/CSPD. The procurement plan consists essentially of PIOs for buy-ins, add-ons, and contraceptive commodities, and local contracting of two PSCs, and audit and evaluation services.

PROJECT SUMMARY

The Reproductive Health Services Project has three components: (1) support for GOB reproductive health activities; (2) private, non-governmental reproductive health activities coordinated with the GOB; and (3) social marketing of contraceptives. In addition funds will be made available for project management to contract a local professional PSC and secretary; audit, evaluation, and logistical support; and procurement of contraceptive commodities through AID/W. These components are described in detail in Part III, page 14. Through a PGA with the GOB, the Project will assist the Ministry of Health, the Bolivian Institute of Social Security, and the National Population Council to provide family planning services, information and education about reproductive health, training, research, and policy development. The NGO component will continue to develop the same capabilities in private organizations in Bolivia. The third component will provide funds to support the continued expansion of the social marketing (retail sales) of contraceptives (condoms and pills) through a private Bolivian firm. All

participating agencies and organizations including USAID will be represented on the technical subcommittees of the National Coordination Committee for the Project, which have already been established in order to provide mutual reinforcement among elements of the Project.

The goal of the Reproductive Health Services Project is to improve maternal and child health in Bolivia which is adversely affected by the very limited availability and use of reproductive health services of all kinds. The purpose of the Project is to increase access and quality of reproductive health services in Bolivia. The basic Project theme is to promote greater coverage and continued use of reproductive health services, utilizing public and private sector mechanisms to improve the extent and quality of service delivery.

The Project will promote administrative improvement in reproductive health service delivery, through operations research (OR); extensive training of managers, clinical-workers and community-level workers; strengthening systems for logistics and management information; and strong information, education and communication (IEC) efforts to enhance overall Project performance. TA consultants, provided through buy-ins and add-ons to S&T/POP central projects, will assist in all aspects of the Project in a coordinated manner.

The following objectives, established for 1994, will facilitate measurement of interim and End-of Project Status (EOPS) progress in achieving the Project purpose:

INDICATOR	1994 OBJECTIVE	1989 LEVEL
Contraceptive Prevalence Rate (overall)	40%	30%
Modern Contraceptive Prevalence Rate	17%	12%
Traditional Contraceptive Prevalence Rate	23%	18%
Infant Mortality Rate	82/1000	102/1,000 (169/1,000)
Maternal Mortality Rate	39/10,000	48/10,000 Live births

II. PROJECT BACKGROUND AND RATIONALE

A. INTRODUCTION

Bolivia currently has the highest rates of infant and maternal mortality in Latin America, and vies with Haiti for the highest rates in the entire Western Hemisphere. Infant mortality is currently estimated at 102 deaths per 1,000 live births. (Encuesta Nacional de Población y Vivienda, INE/UNFPA, 1988). (While this rate is much lower than the rate of 169 deaths per 1,000 live births used officially by the GOB, it is still the second

highest rate in the Western Hemisphere region.) In the country's most impoverished regions, one child in three does not reach its fifth birthday.

Maternal mortality is estimated to be 48 deaths per 10,000 live births. Causes of maternal mortality were investigated in a study in the German Urquidi Maternity Hospital in Cochabamba in 1987. Of the 70 maternal deaths studied, 94% were directly related to pregnancy or childbirth, 44% of the deaths occurred during pregnancy, 44% during puerperium, and 11% during birth. Of the 29 deaths which occurred during pregnancy, 13 (45%) resulted from infections of induced abortions. The abortion rate in Bolivia is extremely high; 23 per 1,000 women of reproductive ages. One third of maternal deaths are attributed to self-induced abortions, and it is estimated that approximately 48% of admissions of women to the gynecological wards of the hospitals of the Social Security System are of women suffering from abortion complications. According to a study by the Bolivian Society of Obstetrics and Gynecology in 1986, the percent of induced abortions in single women was found to be three times greater than for married women. Of the total abortions reported during the year of study, 8% were performed on women between the ages of 14-19.

Fertility in Bolivia is also high - 5 births per woman according to the 1989 Bolivia Demographic and Health Survey (DHS). Further, it is estimated that over 42% of births in Bolivia are to women whose last birth was less than two years previously. Other high-risk pregnancies, those which occur to women less than 20 years of age or older than age 35, or to women with more than three children, are also common. Among women interviewed for the DHS not using contraception, 74% expressed the desire to have no more children, and 9.4% do not wish to have another child immediately.

The use of family planning, which could avoid abortions and reduce both infant and maternal mortality by enabling women to avoid high-risk pregnancies, is very limited. The 1989 DHS indicated that only 20% of women of reproductive ages used any methods of contraception and only 12% used modern methods. This is up slightly, from 26% and 11% respectively, in a 1983 survey.

Ideological opposition among those who confuse family planning with population control has been extremely strong in Bolivia and effective in preventing the public discussion, widespread knowledge, or acceptance of family planning as a reproductive health service. These groups argue that family planning will lead to Indian genocide and a failure to populate adequately large areas of Bolivia that currently have very low population densities. Religious groups have also been a powerful source of opposition.

Both political and religious sources of opposition to reproductive health have been responsible for major setbacks to the acceptance of family planning in reproductive health services in recent decades. Most Bolivians feel that their country needs more people to defend national sovereignty, popular interests, and social development. An internal 1987 World Bank draft

report was fiercely criticised for recommending that population growth be checked in the face of widespread poverty and unemployment. Activities supported by the U.S. have been particularly vulnerable to attack. In 1971 the Peace Corps was expelled from Bolivia as a result of unfounded charges that Peace Corps Volunteers were sterilizing Bolivian women. Nearly 20 years later, many educated people still believe that the charges were valid. The Peace Corps returned to Bolivia in April 1990. U.S. based private voluntary organizations still encounter accusations that the food aid they provide is tainted with sterilizing agents. In 1976 the IPPF affiliate, PROFAM, was shut down by the government in response to the demands of the Catholic Church. In 1982 a resolution was adopted by the Ministry of Health (MOH) forbidding PVOs from working in family planning. The resolution is still in effect, although not generally applied, especially to local organizations. However, some international PVOs (not involved in this Project) are expressly forbidden from carrying out reproductive health activities by agreements they signed with the MOH.

At present there is no explicit government program for family planning in Bolivia. However, in the past decade, the argument that family planning is a basic human right has slowly, but steadily, been gaining ground. The change is the result of various studies and national surveys which point to the fact that Bolivian women have for many years been controlling their own fertility (it would be biologically possible for most women to have up to 20 children, and yet the national average is 5.1) and which show growing concern about the high incidence of abortion and maternal mortality (a horrifying average of once every 208 pregnancies).

A lack of data on population, health and environment has made it difficult to address ideological and nationalistic arguments. The last census was in 1976. Data which could be used to analyze the health effects of fertility patterns, such as births spaced too closely, are lacking. Until the 1989 DHS, there was limited information available on demand for reproductive health or on the availability of services. In addition to a lack of appropriate data, there has been a failure to use what information is available effectively to address the issue of reproductive health. The result has been a perception among policymakers and leaders that there is very little demand for family planning from the population. As a result, until recently virtually no one in a position of leadership has been willing to support publicly even the idea of reproductive health. This lack of willingness to support reproductive health publicly persisted in spite of findings from a 1985 survey of 522 national leaders which indicated that over 90% of them supported making reproductive health services available throughout the country. Moreover, the few Bolivian organizations which have provided reproductive health services which included family planning in the years following the 1982 MOH resolution have done so quietly, not even identifying themselves as organizations providing such services. Few have signs in public that indicate that they offer reproductive health services, much less family planning methods. In short, Bolivia exhibits maternal and child mortality rates as high as those of severely underdeveloped countries in Africa and

Asia, coupled with a historical and cultural antipathy toward family planning services.

However, there have been some significant changes recently that suggest that there is a much greater potential now to support the expansion of reproductive health services than ever before. First, abortion rates appear to have increased dramatically in the last five years. This is thought to reflect the dire economic conditions that prevailed in the mid-1980s, and it is being increasingly accepted as an indicator of the demand for reproductive health services. Second, there appears to be increasing embarrassment among influential Bolivians regarding Bolivia's health status compared to other countries in the region, as reflected by its high maternal and infant mortality rates, and increasing recognition that a wide variety of interventions, including reproductive health services which include family planning, are needed to improve health conditions. Third, a USAID-financed conference, which was sponsored jointly by the MOH and the Catholic Church, held in La Paz in March of 1989 entitled "The Fight Against Abortion" suggests that there have been significant advances among traditional sources of opposition, notably the Catholic Church, in recognizing the health benefits of family planning. A summary of the conclusions and recommendations of the conference indicates support for government-sponsored sex education and for providing information and services to enable couples to practice voluntary family planning in order to combat the high incidence of abortion and improve the health of mothers and children. This marks a dramatic advance in public support for reproductive health services. Finally, the conference marked the beginning of a new effort by the MOH publicly to address subjects with implications for reproductive health. The MOH sponsored two seminars in 1989, one on adolescent health and another on reproductive health. At another seminar held by the MOH in April 1989, the universities in La Paz, Cochabamba, and Sucre agreed to integrate family planning in the context of reproductive health into their curricula for doctors, nurses and public health workers. In November 1989 the Ministry of Health issued a decree to provide Reproductive Health services in GOB clinics by 1992.

Despite these changes there exists an atmosphere that is still potentially "explosive" (as one Minister put it), and all observers agree that any effort to support the expansion of reproductive health information and services must be based on the following premises. Reproductive health services must be provided in the context of overall health services addressing the needs of women and children and from the perspective of ensuring women's fundamental rights to reproductive freedom. It must be based on voluntary demand as indicated by women and couples, not as defined and dictated by a few policymakers, since at this point Bolivians vehemently reject the support of any activities that might be used to develop a policy of "birth control." Family planning services can only be provided effectively in the context of a much greater level of awareness and understanding of what reproductive health is in relation to existing beliefs and values regarding reproduction and family development. Finally, the role of U.S. financing should be designed in light of past setbacks. Coordination with other donors and among local

organizations, as is being done by means of the National Coordinating Committee for the Project, is extremely important. In addition, reproductive health and other health programs must be addressed in a coordinated fashion at the same time as the country strives to develop its agricultural, industrial, and human resource sectors.

Relationship to USAID Strategy

Of all the social sectors in which USAID might intervene in Bolivia, maternal and child health has been identified as the area in which our involvement can make the greatest contribution. Bolivia's performance in this area continues to be the worst in Latin America. Current opportunities for improvement are therefore great, and USAID's comparative advantage is widely acknowledged. A central element of the USAID strategy for Bolivia consists of funding for programs that improve the quality and scope of service delivery, promoting needed policy review, and encouraging greater use of private sector delivery mechanisms. In addition, USAID is also interested in identifying mechanisms that generate greater demand for reproductive health services, (e.g. through information, education and communication initiatives.)

The efforts to reduce the current high levels of fertility and mortality complement the other development strategies that are central to the USAID program of assistance in Bolivia, such as increased agricultural production, and stimulation of private enterprise and service delivery.

Project's Relationships to GOB Health Sector Activities

The Ministry of Health (MOH) is responsible for the overall activities of the public sector in support of the health of the Bolivian population. Together with the Caja Nacional de Salud (CNS) under the Bolivian Institute of Social Security (IBSS) and the Armed Forces, the MOH provides health services to the population as a public service. In theory the MOH covers 68% of the population. In fact, the MOH's real coverage of the population is about 40%, and in rural areas probably does not reach more than 20% of the population.

In response to the problem of the high rate of abortions and their complications, the Maternal Child Health Division (MCH) of the MOH undertook a limited campaign against abortions in 1987. This effort includes providing reproductive health information and services to women who become hospitalized with complications from abortions or attempted abortions. USAID provided a $31,500 grant in support of the program which was to start in four MOH institutions in La Paz, Cochabamba and Santa Cruz in the first year and be extended through 12 institutions throughout the country by the end of the third year. The effective use of contraceptives to be achieved was 30% (645 women) of patients hospitalized for incomplete abortions during the first year, 45% (2,440 women) of such patients during the second year and 60% (6,510 women) during the third year. The program did not get underway effectively until the beginning of 1988. During the three years of its operation it

succeeded in providing contraceptive services to only a few women in the Hospital San Juan de Dios in Oruro, and Hospital Obrero of IBSS in La Paz. The attempt to undertake a program in the MOH facilities in La Paz was thwarted by opposition at that time from the medical faculties in that city.

In November 1989 the MOH issued, with USAID/B encouragement and support, a National Plan for Child Survival, Development and Maternal Health. It covers the period through the year 2000, and sets forth targets for improvement by the year 1993. Among the targets in the plan are the following:

-- reduce the maternal mortality rate (48/10,000 live births) by 50% by 1993;
-- reduce the perinatal mortality rate (110/1000 live births) by 30% by 1993;
-- reduce the infant mortality rate (169/1000 live births) by 50% by 1993; and
reduce the mortality rate among children 1-4 years old (23/1000) by 30% by 1993.

The Plan does not contain budget estimates nor is it divided into specific projects for financing. USAID considers these targets laudable, but believes they are overly ambitious. However, the emphasis on reducing infant, child and maternal mortality is appropriate and the reproductive health intervention is sound.

The CNS also provides reproductive health services, but to date it has reached only 650 women on a sustained basis. However, it has a concrete proposal for expanding that coverage.

The GOB's health sector activities are concentrated in the MOH and the IBSS, although two institutions within the Ministry of Planning also provide information relevant to the implementation of these activities: the National Statistics Institute (INE) and the National Population Council (CONAPO). INE collects national level data useful for establishing baseline information for health programs and for evaluating their impact on maternal and child health. During 1988-89, INE carried out three surveys which will provide valuable, current information related to health programs: the Population and Housing Survey, the Demographic and Health Survey, and the Integrated Survey. CONAPO serves as the main resource to both the public and private sectors for all population information, carries out analyses on population issues, and publishes material on population-related subjects.

USAID-Sponsored Activities Related to Family Planning

USAID funding of reproductive health-related activities in Bolivia, especially family planning, has been sporadic and limited since the mid-1970s, reflecting the high degree of sensitivity surrounding reproductive health and the historically controversial role attributed to the USG on the subject. The

USAID Mission in Bolivia is currently funding reproductive health-related activities in the public sector, such as the seminar on abortion problems. Most of these funds are for activities carried out by the MOH through the project to fight abortion ($31,500).

There are also activities funded through central AID/W cooperative agreements and contracts, but there has not been enough collaboration among them. For example, CONAPO currently receives funds for selected health and reproductive health-related studies through such arrangements. In addition, several Cooperating Agencies are working with several of the Bolivian private organizations which provide reproductive health services. Annex K is a listing of the activities funded by USAID/B and Cooperating Agencies currently active in Bolivia.

The $22 million, five year Child Survival Project funded by USAID contains several activities complementary to those proposed for this Project. Relevant activities include breastfeeding and tetanus toxoid immunization campaigns, as well as data analysis efforts which will be useful in evaluating the impact of the Reproductive Health Services Project.

Project's Relationship to Other Donor Activities

A number of projects and activities are currently being planned or supported by other donors that will be complemented by the proposed Project.

In November 1988 the Pan American Health Organization (PAHO), with financial support from the UN Fund for Population Activities (UNFPA), initiated a three-year, $2 million project (called PRONIMA III) to provide potentially reproductive health information and services to one million women through the MCH program of the Ministry of Health (MOH). The program is designed to extend reproductive health services to reduce infant and maternal mortality. The Project will assist the Ministry in defining, equipping, staffing, and beginning general health services in 100 newly-defined health areas, especially in marginal urban areas; and will provide some support for 150 areas previously established. The PAHO Project will include support for services delivery, including personnel, operating funds, logistical support, supplies (including contraceptives), development of norms, and the detection of cancer and other gynecological diseases. Training in family planning methods for doctors, nurses, and traditional birth attendants will be included, as well as for operations research and in information, education, and communications technologies. A management information system will be developed in coordination with this Project's MIS. Operations research and evaluations studies will be carried out, and educational materials developed and disseminated. Family planning methods will be provided at 22 hospitals and maternities, and include condoms, pills, and IUDs.

PAHO has also assisted the MOH in the design of a National Plan for Child Survival Development and Maternal Health in conjunction with WHO's Health for All by the Year 2000 program. The Plan specifically states an

objective to have reproductive health services available in all health facilities by 1992. Reproductive Health is described as including education for sexual life and for the couple; reproductive risk classification; promotion, education, and facilitation of all methods of child spacing, according to need and the decision of the user; tetanus toxoid immunization; prevention of sexually transmitted diseases and AIDS; detection and treatment of nutritional deficiencies; detection and treatment of specified gynecologic diseases; and detection of cervical cancer.

PAHO has expressed an interest in supporting activities in several areas of relevance to this Project: training (perhaps in conjunction with JHPIEGO) for medical personnel, sex education, further analysis of survey data (DHS) for program needs, and the dissemination of that data. PAHO has committed $15,000 and has expressed an interest in committing more to the data analysis and dissemination efforts, especially the 1993 DHS.

The World Bank currently is designing a $40 million, five-year Project to assist the MOH to develop local health systems in the four largest urban areas of the country: La Paz, El Alto, Cochabamba, and Santa Cruz. The Project will assist in the development of physical and human resources and in institutional strengthening. The World Bank Project will also strengthen the data collection capacity of the MOH through an agreement to support collaboration between it and INE, including the development of a database for the evaluation of health efforts with data from the major surveys currently being conducted by INE and other relevant information. This last component is estimated to cost $40,000, and will complement the proposed Project, since the same data will be used to establish baseline measures for both Projects.

UNICEF supports primary health care, but does not directly support the provision of reproductive health services; although it does so indirectly via lactation promotion and verbal support for birth spacing and the avoidance of unwanted pregnancies. UNICEF will introduce a module entitled "Facts of Life" in 1990, and in 1991 will introduce material on birth spacing. This seems to be the most likely area of collaboration with the Project.

Another potential source of activities that could complement the Project is the efforts of international PVOs to provide primary health education and services. In an assessment of interest conducted in January 1988, several of those PVOs expressed interest in supporting child spacing for maternal and child health. Many are limited at this time, however, by their agreements with the GOB written in accordance with the 1982 MOH resolution prohibiting PVOs from engaging in reproductive health activities either directly or through referrals. Several PVOs indicated an interest in supporting reproductive health services for health reasons if such efforts were approved by the MOH.

Cooperation between USAID and the above mentioned groups, and other major international donors has been excellent. For example, USAID is a member

of the Interagency Coordinating Committee for EPI, AIDS, and MCH activities with UNICEF and PAHO. The U.S. child survival PVOs have formed a coordinating body, The Coordination Program for Child Survival (PROCOSI).

The National Coordination Committee specifically established for this Project includes PAHO as an observer, and each of the technical sub-committees have one international agency as an observer; e.g. UNFPA is a member of the research and evaluation sub-committee, and the World Bank is a member of the services sub-committee.

PROJECT RATIONALE

Given the objectives of the GOB's child survival plan, the 1990 - 1994 Reproductive Health Services Project has as its main goal to assist Bolivia in improving maternal and child health by reducing current high levels of infant, child, and maternal morbidity and mortality associated with closely spaced and other high risk births.

The Reproductive Health Services Project will increase the use of selected reproductive health services, which will include modern family planning methods, including scientific natural family planning methods (NFP) and appropriate breast feeding practices, and, where possible, screening for and referral of cervical cancer and sexually-transmitted diseases (STDS). This goal should encourage balanced demographic change at the household level.

The underlying rationale for this approach is based on overwhelming evidence that reproductive health technologies, when effectively deployed, can substantially reduce the proportion of women hospitalized for abortion complications and reduce the proportion of closely-spaced births.

Based on research studies elsewhere, when latent demand for culturally appropriate reproductive health services is effectively met, the result is an increase in contraceptive prevalence and lower fertility and mortality among the most vulnerable segments of the population; namely, mothers and children. Reducing high risk births (i.e. births to women under age 18 and over age 35, parity four births and above and births occurring at intervals of less than two years) has been shown to significantly improve maternal and child health (e.g., see Trussell and Pebley, 1984; Phillips, et al, 1984).

Essential elements of the Reproductive Health Strategy are as follows:

1. Support for Public and Private Bolivian Institutions

The Reproductive Health Services Project will promote increased delivery of reproductive health services utilizing public and private sector mechanisms. The Project will encourage the implementation of effective service delivery strategies, and attention will be given to enhancing service delivery with training, research and evaluation, information, education, and communication, and policy development activities. Also, attention will be

given to developing logistical procedures that encourage adequate and timely provision of reproductive health supplies, and to developing a reporting system and program analysis capabilities through a Management Information System (MIS).

High levels of maternal mortality in Bolivia require program efforts (e.g. safe birth practice training and improved referral systems for pregnancy complication, diagnostic ante-natal care, etc.) to be coordinated with other donor assistance, and with USAID/Bolivia's other health intervention programs.

In assessing the Project's strategy, Bolivian conditions must be kept in mind. Until two years ago the GOB objected to the fostering of the use of reproductive health services by the Bolivian population. At that time the health authorities of the GOB began to be aware of the adverse consequences on the health of women of the use of abortions as a family planning method, and of the positive consequences on the health of women of increasing the spacing of pregnancies. As a result, the de facto policy of the GOB's health authorities changed to support the provision of reproductive health services for women who are at high risk of medical problems during pregnancy and who had previously had abortions. However, the provision of reproductive health services continues to be potentially controversial --both from the point of view of some of the religious groups and from the point of view of certain political currents in Bolivia. Partly because of this potential for controversy and the past experience of government "crackdowns" on the providers of reproductive health services, and partly as the result of the weakness of the institutions themselves, the Bolivian agencies providing reproductive health services have been conservative in their approach. Thus, the Project's strategy must build on a relatively recent opening based on health considerations and use institutions whose current user levels are quite small and whose institutional preparation in general is weak. For these reasons, the expectation of the near term results of the strategy must be modest and the health rationale for the Project must be kept in mind in planning the interventions to be supported.

2. Improving the Quality of Care

Analysis of the 1989 DHS indicates that over two-thirds (67.8%) of currently married women in Bolivia expressed a desire to end child bearing, including more than 50% of 20-29 year olds. However, the proportion of all currently married women who wish to space their births at least two years apart is only 8.9%. In order to meet the need, increased attention will be given to making information and services available. This will be supported through better information, improvements in outreach by the GOB delivery system, expanded PVO service delivery, and targeted distribution strategies utilizing social marketing. Attention to quality of care will be essential, since the quality of care is a major factor affecting initial adoption and continued use of reproductive health services. Clinical services must be provided by well-trained persons, along with appropriate counselling and follow-up. Under the proposed Project, USAID's efforts to improve the quality of reproductive health services will include training (community workers,

managers, clinical staff), provision of technical and commodity support, and information, education and communication (IEC) activities to improve public awareness, attitudes and knowledge towards reproductive health risk factors, family planning methods, and the sources of services among potential users. Based on experience in other countries these types of IEC activities will encourage increased use of reproductive health services.

A complementary component of USAID's Reproductive Health Services Project will incorporate operations research as a tool for improving both the availability and quality of GOB and PVO services. In addition, activities which will develop, compile, analyze, and disseminate information pertinent to population dynamics and reproductive health will be enhanced.

PROGRAM OBJECTIVES OF THE USAID REPRODUCTIVE HEALTH PROJECT

The Reproductive Health Services Project's objectives and program priorities are essentially consistent with the goals and implementation strategy articulated by the GOB in its National Plan of Child Survival Development and Maternal Health, 1989-1993. However, USAID believes that official GOB health objectives may be overly ambitious given the relatively short five year planning period.

The major component is to support Reproductive Health in Bolivia as shown in Table 1. USAID anticipates that contraceptive prevalence in Bolivia will reach 40 percent by the end of 1994. Modern method use is projected to reach 17 percent of all eligible couples, while traditional methods will account for 23 percent of contraceptive use. The prevalence objectives can be achieved given effective and timely program implementation.

TABLE 1

PROJECTED TREND IN CONTRACEPTIVE PREVALENCE

Percent of All Couples Aged 15-49 Using Contraception

	1989[1]	1994
Total	30	40
Modern	12	17
Traditional	18	23

[1] The 1989 DHS

Key Results of the 1989 DHS were:

1. Fertility:

The total fertility rate (TFR) for 1985-89 from the Survey is 5.1 children per woman. While the TFR appears to be declining, there are large rural-urban differences in age-specific fertility rates.

2. Fertilility Preferences:

Over two-thirds (67.8%) of currently married women in Bolivia expressed a desire to end childbearing, including more than 50% of 20-29 years olds. However, the proportion of all currently married women who wish to space their births at least two years apart is only 8.9%.

3. Contraceptive Knowledge and Use:

Awareness of modern contraception and knowledge of a source are quite widespread in Bolivia. Seventy-five percent of currently married women have heard of one or more contraceptive methods. The most commonly mentioned method is rhythm (54.5%), followed by IUD (54.1%), and pill (52%). Thirty percent of currently married women are currently using contraception; rhythm is the most commonly used method (16.1%), with IUD a distant second (4.8%). There are also large differences in contraceptive use by urban-rural residence and education.

Roughly 28% of current users obtain their contraceptives from private doctors. Among respondents who named a specific source, friends and family are the next most likely source (17.7%), followed by public hospitals (13.8%).

4. Maternal/Child Health:

One in six children (15.5%) under the age of five experienced an episode of diarrhea within the 24 hours immediately preceding the interview. Twenty-eight percent had an episode in the previous two weeks. ORT was administered to 26.2% of these.

Fewer than one in five children under five years of age has a health card. Of those that do, 62.7% have received BCG; 51.7% have received the complete series for DPT; and 65.6% are protected against measles. However, only 26.1% have received the complete series for polio.

Only twenty percent of women who had borne a child in the last five years had received a tetanus toxoid injection during pregnancy. Forty-four percent received their prenatal care from a doctor or nurse and 40% were assisted by a professional at delivery.

Demographic estimates for 1989 are shown in Table 2.

TABLE 2

DEMOGRAPHIC ESTIMATES FOR 1989

(1989)

Total Population	6.4 million[1/]
Annual Growth Rate	2.2%[1/]
Crude Birth Rate	40 births per 1,000 population[2/]
Crude Death Rate	14 deaths per 1,000 population[2/]
Total Fertility Rate	5.1[3/]
Life Expectancy	53 years[2/]
Infant Mortality Rate	102 deaths per 1,000 live births[1/]
% of Population under age 15/65+	43/3[2/]

Source: [1/] National Housing and Population Survey, 1988
[2/] Population Reference Bureau, 1989
[3/] DHS, 1989

III. PROJECT COMPONENTS

The 1990 - 1994 Reproductive Health Services Project contains three components which are support for: (1) GOB reproductive health activities, (2) private NGO reproductive health activities, and (3) social marketing. Specific GOB sub-components will be carried out by GOB agencies with technical assistance and program support from AID/W Contractors and Cooperating Agencies. These same Contractors and Cooperating Agencies will provide services to local NGOs (component II.) The following Table 3 provides an overview of project components and sub-components.

COMPONENT I

SUPPORT FOR GOVERNMENT REPRODUCTIVE HEALTH ACTIVITIES

A. Services

The basic approach of the Project is to provide financial resources and technical assistance to service delivery organizations which can significantly expand their provision of services during the Project.

Resources will be provided to the Ministry of Health's National Directorate for Maternal and Child Health (MOH/MCH) for service facilities in La Paz, Cochabamba, and Santa Cruz; the Bolivian Institute of Social Security (IBSS/CNS) for maternal/child health services nationwide; and to local PVOs through U.S. CAs (Component II). The Project will assist the MOH/MCH in the extention of services to areas not already covered by the MOH's Project for mothers and children (PRONIMA), sponsored by UNFPA and PAHO. In addition, the Project will assist IBSS/CNS to add reproductive health services to selected urban clinics throughout Bolivia. IBSS/CNS plans to provide the broad spectrum of reproductive health services for men and women, including child-spacing, breastfeeding practices, STDs and cancer screening, detection of high risk pregnancies, etc. The IBSS/CNS has care facilities for treatment of STDs and cancer.

B. Information, Education and Communication Services

In general, there is a lack of information about the cultural beliefs and practices surroundings pregnancy, delivery, and the neonatal period, including the utilization of health services. Basic research needs to be undertaken prior to communication and education efforts as well as the delivery of reproductive health services to assist the public as well as the private sector in a wide range of IEC activities in order to expand access to reproductive health information and services.

The rationale for the information, education, and communication (IEC) component of the Project is to create voluntary, informed demand for selected reproductive health services among the populations of the target areas. This will contribute to increased access to reproductive health services by increasing the knowledge among married women of reproductive age of the high risk factors for pregnancy, family planning methods, and sources of supply. The strategy will be to work with participating service providers to develop and disseminate educational and promotional materials for their clinics, to assist them with community outreach, and in the later years of the Project, to conduct mass media campaigns for the general public. This activity requires collaboration with the MOH/MCH, IBSS/CNS, MOP/CONAPO, the Social Marketing Project, and NGOs, among others. There is a need to develop a coherent communications strategy to coordinate reproductive health messages to ensure that they are mutually supporting. Specifically, USAID will support research; message development; creative use of wider variety of communications channels; improved communications training; and development and dissemination of service provider, fieldworker, and client educational materials.

Technical assistance for these IEC activities will be provided by the Population Communications Service (PCS), an AID/W ST/POP contract currently held by Johns Hopkins University, and its successor contract.

TABLE 3

PROJECT COMPONENTS AND SUB-COMPONENTS

COMPONENT OR SUB-COMPONENT	NATIONAL IMPLEMENTATION ORGANIZATION	INTENDED OUTPUT OF COMPONENT OR SUB-COMPONENT	ASSISTANCE PROVIDED
COMPONENT 1: SUPPORT FOR GOB ACTIVITIES		Increase capacity of MOH/MCH and IBSS/CNS to deliver reproductive health services through health practices and to increase analysis capabilities and use of demographic data through MOP/CONAPO	
SUB-COMPONENTS			
A. Services	MOH/MCH IBSS/CNS Buy-in-PATHFINDER	Increase capacity to deliver services	TA in comprehensive service delivery
B. Information, Education and Communication	MOH/MCH IBSS/CNS MOP/CONAPO Buy-in-PCS/JHU	Increase capacity to deliver services	TA support for research training and innovative field program
C. Training	CONAPO MOH/MCH IBSS/CNS Buy-ins-JHPIEGO, DAI FPMT/MSH	Increase number of trained persons to provide services	TA, training
D. Research/Policy Monitoring	IBSS/CNS MOP/CONAPO Buy-ins-OPTIONS, RAPID/TPC Pop Council	Monitor impact, improve planning, OR, MIS, conduct 1993 DHS	Research and training, TA

E. Local project management support, commodities	USAID/B, GOB, NGOs National Coord. Committee	Funds for local management, contraceptives, evaluation, audits and other delivery activities defined at a later date Strengthen coordination among all sub-component, guide implementation efforts, provide required project commodities.	TA, contraceptives commodities, logistical support
COMPONENT 2: SUPPORT FOR NGO ACTIVITIES		Complement, extend range and availability of reproductive health services	
SUB-COMPONENTS:			
A. PATHFINDER	CIES, Fundación San Gabriel	Expand service delivery	TA, service delivery systems development
B. MOTHERCARE	SERVIFAM, ENFE	Expand service delivery system development	TA, service delivery
C. JHPIEGO DAI FPMT/MSH	CIES, Fundación San Gabriel SERVIFAM, FAMES, CIS, PROSALUD, COF, SBCO, CROF, FEPADE	Medical, clinical training community community staff training, management training	TA, training, OE, etc.
D. PCS/JHU	CIES, Fundación San Gabriel SERVIFAM, FAMES, CIS, PROSALUD, COF, SBCO, CROF, FEPADE	IEC	TA, research, training and development of initiative programs
E. POPULATION COUNCIL	CIES, other appropriately selected PVOs	OR research and dissemination	TA, research, OE, etc.
COMPONENT 3: SUPPORT FOR SOCIAL MARKETING		Make retail market effective channel for delivering contraceptives	TA, IEC, research, commodities
A. SOMARC	Abendroth	Make contraceptives commodities available	TA, IEC, research, distribution, commodities

C. Training

Bolivia suffers from a lack of reproductive health training resources and has a relatively small number of persons trained in techniques relevant to providing and promoting services in reproductive health. The training component of the Project will train a large number of personnel of organizations now providing reproductive health services to the public or which have the potential to provide such services, such as the Ministry of Health (MOH). The areas to be addressed are clinical training of M.D.s, nurses and other service delivery personnel; technical training of paramedical and community outreach personnel; training of service providers in interpersonal communication; management training of directors and administrators of the participating organizations; training in IEC techniques for selected personnel of service provider organizations; operations research training for service provider organizations; and evaluation training for all service providers participating in the Project. Strengthening of the overall management capabilities in the MOH/MCH and IBSS/CNS will include improving management systems, such as record-keeping, budgeting and planning, maintenance of medical standards, efficient handling of commodities, strategic planning and finance management. To meet these management and administration needs identified by the service providers, Management Services for Health (MSH) and its successor contract will continue to provide training in finance, marketing and sales as part of the Family Planning Management Training Project (FPMT), funded by ST/POP. Training for pharmacy personnel will be provided under the SOMARC program. In addition, three medical schools will be assisted to widen their curricula to incorporate family planning topics and strengthen their reproductive health curricula.

The training component builds on training activities that are currently being conducted in Bolivia with the assistance of AID/W funded U.S. Cooperating Agencies, (JHPIEGO, FPMT/MSH, DAI, PCS/JHU, Population Council) and will utilize those US Cooperating Agencies to provide technical expertise in each training subject.

D. Research/Policy Monitoring

Operations Research/MIS

The rationale for the research and evaluation component of the Project is to expand the delivery of selected reproductive health services through the most effective choice and efficient implementation of service models. The strategy for this component is to provide technical assistance and funds for implementation of several major activities: a Project-wide management information system, collection of Project generated data (qualitative and quantitative), evaluation studies, operations research

studies, and other studies, as appropriate. Although separate activities, the research and evaluation component will contribute to stronger service agencies by helping them to analyze their problems, to introduce modifications in their activities to resolve their problems, and to assess the impact of their service delivery.

One of the most urgent needs for the service providers in this Project is the establishment of a uniform service statistics system for reproductive health services. Such a system will collect information needed for monitoring and evaluation of service delivery activities, including reproductive risk factors and family planning status. Currently, each organization has its own system, and it is therefore difficult to compare statistics between them, or to develop national statistics from them. The Project will contract with the Development Group, Inc. (DGI), a minority-owned firm, under the AID/W Options Project, to develop and implement such a system. They have recently worked in Peru on a multi-institutional, public and private sector information system for the national family planning program there, which has been reported to be appropriate and effective.

During the course of the five year Project, at least four large operations research or major evaluation studies will be conducted with technical assistance from the INOPAL II Project, an AID/W S&T/POP contract with the Population Council, in both public and private sector institutions. These will assist with the development of high quality services which are culturally and politically acceptable in Bolivia. While topics would be selected by service delivery managers with guidance from INOPAL II staff, the following may prove interesting in Bolivia: service delivery with labor unions; cost-effective service delivery models; self-sufficiency service delivery programs; integrating agricultural assistance and reproductive health activities; low-cost, easily accessible public services; and training interventions. Operations research will be based on an approach which has proved successful in different parts of the world. In addition, a National Demographic and Health Survey (DHS) is planned for 1993 with technical support of the Institute for Resource Development (IRD/Macro Systems), S&T/POP.

Policy Development

Policy development activities under the Project will be undertaken to create an environment supportive of the provision of selected reproductive health services for the purpose of improving maternal and child health. They will address the barriers to the provision of information and services. The activities will not be designed to promote an explicit population policy, as it is universally agreed within Bolivia that such a policy is neither appropriate nor feasible in the near future given the political and ideological attitudes and the confusion that exists between the concepts of family planning and birth control. Indeed, it is essential that all policy development activities funded under the Project address family planning in the context of reproductive health, and not be oriented toward suggesting the need for a policy designed to reduce fertility for macroeconomic purposes.

Project resources will be used to generate, analyze and disseminate data that will inform GOB officials, the health community, the press, other influential persons in Bolivia, and the public at large concerning the issues arising from reproductive health patterns and the growth of population in Bolivia.

The primary focus of the dialogue to be generated by the information will be on the benefits of reproductive health services for women, children and the family in general, giving special attention to the nature and magnitude of the demand for reproductive health services and the need for access to information and services as defined by the target populations. The favorable impact of reproductive health on the health system's resources in view of the expected reduction in the cost of medical treatment related to abortions also will be addressed.

A second area of focus will be on the implications of existing and potential population trends (both growth and redistribution) for sector planning regarding jobs, health, education, and housing resources. To ensure that these analyses are oriented to broadening and strengthening support for voluntary reproductive health services rather than toward a policy of population control, fertility rates used in these analyses will be based on estimates reflecting unmet need for reproductive health as measured by survey results and by existing estimates of abortions, using available models to translate existing abortion rates into potential rates of reproductive health services use and subsequent fertility rates.

Other issues to be addressed in this component include the relationship between population distribution and the environment, focusing on the adverse effects of spontaneous migratory movements on the health of migrants and on land newly occupied by migrants in Bolivia. The orientation of analyses to address these issues will be to promote better planning in response to migrants' needs and to encourage appropriate land use rather than to design policies of forced migration.

Organizations currently involved in producing information on population questions include the National Population Commission (CONAPO), which is part of the newly created Secretariat for Social Policy in the Ministry of Planning, and INE, the National Statistics Institute. For demographic and policy analysis MOP/CONAPO will work with the RAPID III Project of AID/W in three areas. These include: (1) awareness raising focussing on key population issues and trends; emphasizing the health and economic benefits of providing reproductive health services; and the magnitude of unmet demand for these services; (2) data collection emphasizing the development of a data bank on demographic trends, socio-economic conditions and reproductive health; and (3) planning for implementation of the Bolivian reproductive health program including data modeling and analysis. The Population Council will also support the activities of the technical subcommittees on Research/Evaluation and Policy and maintain an advisor in country.

F. Management Support

The bilateral agreement will also contain funding for necessary management support for the GOB portion of this project and the various AID/W cooperating agencies and contractors. This management support will include the following:

1. Contraceptive Procurement

Contraceptive commodities will be ordered by PIO/T from S&T/POP/CPSD through established procedures for worldwide procurement of condoms, pills, and IUDs. Funds for audit, evaluation and logistical support (e.g. project-related communication) will be obligated through the Project Grant Agreement.

2. USAID/B Project Management Unit (PMU)

The Project Manager will be an FS-1 direct hire BS-50 Foreign Service employee with experience in managing large population programs. The Project will fund a Bolivian PSC Population Advisor, supported by a Bolivian PSC secretary, both within USAID/B's Office of Health and Human Resources. These three employees will be the Project Management Unit, reporting to the Chief, HHR. The PSC Population Advisor's primary functions will be to guide the implementation of the Project, serve as executive secretary for the National Coordination Committee, and attend meetings of the technical sub-committees. The Population Advisor will monitor and provide assistance to the GOB and NGO reproductive health programs and coordinate Project activities with the Office of Health and Human Resources.

3. Evaluation and Audit

See Annex J (Data Collection, Monitoring and Evaluation).

4. AID Logistical Support

AID Logistical Support for AID/HHR/PMU personnel will include communication expenses, travel and local transportation costs, office supplies and materials, and office equipment.

COMPONENT II

PRIVATE NON-GOVERNMENTAL REPRODUCTIVE HEALTH ACTIVITIES

With careful planning, private non-governmental organizations including contractors, cooperating agencies, and NGOs can complement activities of the GOB, thereby improving access and coverage. NGOs are

flexible and can respond quickly. Close GOB-NGO collaboration in support of national reproductive health program will be fostered by the National Coordination Committee established for this Project.

At present, several AID/W Cooperating Agencies and Contractors have been working with the GOB and Bolivian NGOs on several activities with: The Center for Investigations, Education and Services (CIES) and the Fundación San Gabriel, both in La Paz; SERVIFAM in Cochabamba; PROSALUD in Santa Cruz; and the national contraceptive social marketing system organized by SOMARC. The current level of reproductive health services provided by these organizations is small. With the assistance of the Project, those institutions should be able to increase their level of activity. In addition to these institutions with which the Project will work from the beginning, there are a number of institutions whose potential is more limited, but which might be encouraged or be significantly helped by in-kind support. However, it is not possible to project in advance the level of active family planning users which might result from those interventions.

The Reproductive Health Services Project will continue to provide support to Bolivian NGOs through existing AID/W Cooperating Agencies and Contractors; these agencies in turn will provide direct support for technical assistance, services and related activities, initially in urban areas of Bolivia. (See Annex M for more information on each CA/Contractor.)

A. The Pathfinder Fund

The Pathfinder Fund will provide technical and financial support for service delivery in reproductive health. Pathfinder will continue supporting CIES' ongoing service delivery in La Paz, Oruro and Potosi through 3 modalities (3 clinics; 65 community workers; and 38 affiliated physicians). Collaborating with other Cooperating Agencies for strategic planning, training, IEC and other related support activities, including the provision of contraceptive commodities, Pathfinder will also work with the CNS and the Fundación San Gabriel.

B. MotherCare

In November 1989, John Snow, Inc., the contractor for MotherCare, an AID/W central Project, made an initial assessment of a project to provide an integrated package of prenatal, birthing, and family planning services to women living in the urban and peri-urban areas of Cochabamba. Their planned major activities with SERVIFAM, the PVO in Cochabamba, would include: (1) qualitative research; (2) communication strategy designed to reach women and their families with messages that promote appropriate

reproductive behaviors, (3) strengthening maternal and reproductive health services. This program will coordinate their activities via the technical subcommittees. In addition, some funds may be available for service activities of the Empresa Nacional de Ferrocarriles (ENFE) mobile train facility, originally AID/W-funded under the Enterprise Project. MotherCare will have a resident advisor in Bolivia and will support the national technical subcommittees for services/training.

C. FPMT/MSH, JHPIEGO, DAI

Through the FPMT/MSH, support will be provided to the GOB (Component I) and to PVOs with regard to strengthening capabilities through workshops, seminars, and direct technical assistance. In addition, FPMT/MSH will support the activities of the National Coordinating Committee for the Project and will have a resident advisor in Bolivia. With CIES and SERVIFAM, MSH plans workshops on management/institutional development, strategic planning, and financial management. A similar workshop in financial management will be held for other private groups together. A follow-on contract will be let late in FY 90, and the Project will buy into it for continued services in this area. The Project will support additional workshops and training courses for Project participants on the subjects of financial management, marketing and sales, executive training, administration and evaluation. The management training contractor will also provide technical assistance to organizations as they apply the lessons learned from these courses.

The Johns Hopkins Program for International Education in Gynecology and Obstetrics (JHPIEGO), serves as a catalyst for the improvement of reproductive health by providing technical guidance, equipment, educational materials, and funding. Using a buy-in from this Project and some central funds, JHPIEGO will establish nine Women's Health Training Centers to provide public and private sector clinical training for 750 M.D.s and nurses in delivery of reproductive health services, including reproductive risk assessment, temporary family planning methods, such as oral contraceptives, condoms, and spermicides, STD screening and treatment, and Pap smears for the detection of cervical cancer. JHPIEGO also will develop a reproductive health curriculum for medical/nursing facilities at the universities in La Paz, Cochabamba, and Sucre, in collaboration with the PRONIMA III Project implemented by PAHO for UNFPA.

Community outreach and paramedical training and development of an institutional capacity for such training will be provided under the contract for the PAC IIB Project implemented by Development Associates, which is currently working with FEPADE, CIES and PROSALUD. Funding for this activity will come from both a Project-funded buy-in and funds from AID/W. Auxiliary nurses will be trained in provision of family planning methods and

reproductive risk assessment, as well as selected other topics relevant to reproductive health, such as breastfeeding promotion. The MotherCare Project will also collaborate technically with Development Associates in developing the portions of the curriculum beyond family planning.

The Georgetown Institute for Natural Family Planning will provide materials and some technical assistance to JHPIEGO and Development Associates to enable them to include the basic concepts of Natural Family Planning (NFP) methods and the Lactational Amenorrhea Method in their training courses. This will be centrally funded, unless a need arises for training courses for NFP teachers. In that case, a buy-in to that centrally-funded cooperative agreement or its successor may be required.

D. PCS/JHU

PCS/JHU proposes to assist the public and private sector in a wide range of IEC activities in order to expand access to reproductive health information and services. First, the IEC effort will be based on analyses of the needs of the individual participating entities and their particular target populations. Second, the internal communications of the participating entities will be improved before an external promotional campaign is undertaken. Third, information materials will be based on audience research and tested with representatives of the target audiences before being widely used. Fourth, the more general media campaign will not be undertaken until the second or third year of the Project in order to: i) give the participating organizations time to prepare themselves for the increased demand which should be generated by these campaigns; ii) permit the pre-testing of materials to be used in the campaign; and iii) allow the current favorable trends toward the use of reproductive health for health reasons to gain strength before the more assertive advertising techniques are used. Fifth, impact evaluation techniques will be used during the course of the Project so that corrective actions can be taken if necessary. Sixth, although the effort will be based on analyses of the needs of the particular entities involved, the overall effort will be guided and coordinated by the IEC sub committee of the National Coordinating Committee for the Project, consisting of representatives of the participating entities (such as MOH, IMSS, CIES, Fundacion San Gabriel, SERVIFAM, ProSalud, SOMAPC, and CONAPO, with technical assistance from the PCS) in order to: i) assure that the messages do not conflict; ii) share their experiences in the effort; iii) provide joint support of the general information campaigns; and iv) achieve a more cost effective production of materials. In some cases, materials will be translated into indigenous languages for local use; some adjustments in text may be necessary to make them culturally appropriate. Technical cooperation will be sought from Development Associates for materials development for illiterate populations, as they have begun some work in this area.

Other groups working in reproductive health, but who do not receive financial support from the Project, will also be invited to receive

communications training and use the IEC materials developed in their programs as well. During the first years of the Project the staff work for the sub-committee will be supported by the PCS.

During the first two years of the Project, training will be conducted by PCS in IEC methodology, and, in cooperation with JHPIEGO and Development Associates, training in interpersonal communications will be provided to personnel of service providers who deal directly with clients. These are described in other sections as well.

E. The Population Council

The Population Council's (INOPAL) proposed activities will support the research and evaluation components of the Project, as discussed in Component 1. Their main objective would be to provide technical assistance to agencies to design, conduct, analyze, and disseminate the results of research Projects. The Population Council would conduct up to four major research and evaluation Projects and would provide a forum for dissemination of OR results and other scientific topics.

The INOPAL Project, will also provide training to service provider organizations in evaluation of reproductive health service delivery. Four one-week courses will be offered in reproductive health evaluation principles and techniques. Special attention will be given to instruction in setting realistic, measurable goals and the use of standard performance indicators (new clients, couple years of protection, etc.) Evaluation of information and education programs will be emphasized, and cost and cost-effectiveness techniques will also be taught.

The Population Council will support a resident advisor and the work of the technical subcommittees on research, evaluation and policy.

COMPONENT III

SUPPORT FOR SOCIAL MARKETING

Since 1988 the Social Marketing Project (SOMARC) has provided subsidized sale of contraceptive products in all urban areas through established pharmacies. Currently, pharmacies provide 66% of the condoms and 39% of the contraceptive pills used in Bolivia (Bolivian National Survey of Demography and Health, 1989). Additionally, pharmacists and their staffs will be trained in provision of contraceptive supplies as part of the SOMARC Project in Bolivia. Approximately 2,700 pharmacy employees will be trained during the course of the Project, emphasizing new CSM products as they become available. Refresher training will be provided in the latter years of the Project.

The SOMARC program strategy is to increase awareness of family planning and correct use of modern contraceptive methods. Under the

reproductive health Project, USAID will provide funds to continue management and technical assistance; national personnel costs; transport, other equipment and supplies, and evaluation research.

During the early years of the Project, SOMARC will continue to support general media campaigns on reproductive health topics. As the Project progresses the SOMARC will move to messages more specifically promoting only the Social Marketing contraceptive products. It is expected that promotional materials and media interventions conducted under the IEC Project and SOMARC Project will reach 90% of the urban population in the three main target cities of the Project.

USAID/Bolivia SOMARC has funded a program in La Paz, Cochabamba, Santa Cruz, Sucre and Oruro to provide sex education to women in club settings conducted by the Bolivian Society of Gynecology and Obstetrics (SBGO.) Physicians give the instruction and include information on places at which reproductive health servives may be obtained. The Project will provide support to continue and expand the coverage of this program. It is desirable to have this influential organization of physicians actively involved in the overall effort being supported by the Project.

IV. IMPLEMENTATION, BUDGET AND PROCUREMENT PLANS

A. IMPLEMENTATION PLAN

1. General Implementation Strategy in Brief

The USAID/B HHR Office will assign one DH Population Officer (80% of time), one Bolivian professional PSC (100% of time) and one PSC Secretary to manage this Project for USAID/B. These three persons will constitute the Project Management Unit within USAID/B/HHR. As stated above and below, funds for all three of the GOB subcomponents will be obligated by Project Grant Agreement (PGA). The three GOB subcomponents are: a) The Caja Nacional de Salud (CNS) of the Bolivian Institute for Social Security (INSS), b) the Maternal Child Health Division (MCH) of the Ministry of Health (MOH), and c) the National Population Council (CONAPO) under the Ministry of Planning and Coordination (MPC).

For Components II and III, USAID/B/HHR/PMU will write PIO/Ts for buy-ins and add-ons to AID/W/S&T/POP and S&T/Health central cooperative agreements and contracts under existing central projects, or follow-on projects. Approximately 6 such PIO/Ts will be required initially. In most cases, AID/W prefers a short PIO/T stating amount, country, and a brief description of activities to be carried out, because the central cooperative agreements and contracts already contain detailed budgets and descriptions of activities to be carried out worldwide or regionally. Payment of vouchers under these central instruments will be through AID/W/PFM/FM. Eight out of the eleven central contractors and cooperating agencies (CAs) already work in

Bolivia with either central or USAID/B funding, and already have existing relationships with the GOB and Bolivian NGOs. Some of the contractors and CAs will only be present for a short period (1 year) during the 5-year LOP, e.g. the Demographic Health Survey (DHS) scheduled for 1993. Essentially, the NGO and Social Marketing (SM) Components involve procurement by a 2-page PIO/T of several "off the shelf" fully developed subcomponents, implemented by experienced contractors known to USAID/B/HHR, rather like buying ready-to-use spare parts for a car (e.g. distributor, transmission), rather than trying to build a motor yourself from scratch. The GOB, NGO and SMG Components will be coordinated by the National Coordinating Committee of the Project, described below.

USAID/B/HHR will provide funds to procure the services of two Bolivian PSCs, one professional and one secretary, for the life of the project, and audit and evaluation services and logistical support as needed during the Project. Contraceptive commodities (condoms, pills, and possibly IUDs) will be purchased centrally by AID/W/S&T/POP/CPSD upon receipt of a 2 page PIO/C from USAID/B/HHR/PMU stating dollar amount commodities requested, and shipping information. These commodities will probably be imported through one of the contractors or cooperating agencies with experience in this field, e.g. TFG/SOMARC and Pathfinder. All logistical support will be obligated through the Project Grant Agreement.

2. Project Management Unit

The Project will be managed by USAID/B's Division of Health and Human Resources (HHR). The Chief of that Division will devote approximately 15% of his time to the Project. The Project Manager will be the USDH FS-1 85-50 Population Officer, who will devote about 80% of her time to the project. She will be assisted in the day-to-day supervision of the Project by a professional Bolivian PSC employee of the Mission. The Project will fund the contract services of that employee, as well as a full-time secretary.

3. Technical Assistance and Training

Technical assistance and training under the Project will be provided through buy-ins and add-ons with US Cooperating Agencies and contractors. The nature and extent of the technical assistance and training to be provided to the participating Bolivian organizations by the US Cooperating Agencies and contractors and their estimated costs are indicated in the descriptions of the Project's components above in Part III, and in Annex M.

Table 4 below lists the US Cooperating Agencies and contractors involved in the Project, including two Gray Amendment firms, together with the Bolivian organizations with whom they will work.

TABLE 4

US COOPERATING AGENCIES AND CONTRACTORS PARTICIPATING IN THE PROJECT

ENTITY	PURPOSE OF BUY-IN/ADD-ON	BOLIVIAN ORGANIZATIONS
Long Term Activities		
PCS/JHU	IEC	All
Pathfinder	TA, Service delivery and commodities	CIES, IBSS/CAJA
MotherCare(John Snow, Inc)	Service delivery	SERVIFAM
SOMARC/Futures Group	Contraceptive Social Marketing	Abendroth PROSALUD
Population Council	TA, Operations Research	All
Medium term Activities		
DAI	Service delivery training paramedical)	All
JHPIEGO	Technical training (medical, clinic)	All
FPMT/MSH	Management training (general)	All
Short-term Activities		
RAPID	Policy Analysis	CONAPO
OPTIONS/Futures Group	MIS	All
IRD	DHS (1993)	INE

4. Project Obligation Plan

The following Table 5 illustrates the plan for FY 90 obligations. The chart shows that USAID/B will obligate $1.1 million to the GOB in a Project Grant Agreement during July or August, 1990, and will send fully signed PIO/Ts to AID/W/M/SER/OP for buy-ins and add-ons to five central cooperative agreements and contracts (FPMT/MSH, TFG/RAPID, DAI, Pathfinder, and TFG/SOMARC).

TABLE 5

TABLE SHOWING PLANS FOR

FY 1990 OBLIGATIONS (U.S.$ 000)

COMPONENT	CHILD SURVIVAL FUNDS		POPULATION FUNDS		OBLIGATION MECHANISM
I. OYB	A. DHS/CHS	$ 450			PROJECT
	B. MCH/MCH	$ 250			GRANT
			C. NFC/CCS&FO	$400	AGREEMENT
			D. MANAGEMENT SUPPORT		
			i. PSCs (2)	$150	PROJECT GRANT AGREEMENT
			ii. CONTRACEPTIVE COMMODITIES	$ 50	IAT Transfer to S&T/POP/ CPSD
II. NHD	E. JSI/Mothercare	$ 300			PIO/T Add On
			F. MCH/FPHC	$125	DONE! by OYB Transfer
			G. TFG/HNPID	$150	PIO/T Add On
			H. IAI	$125	PIO/T Add On
			I. Pathfinder	$200	PIO/T Buy In
III. SOCIAL MARKETING			J. SOMARC	$250	PIO/T Buy In
TOTAL		$1,000		$1,450	

Total FY90 Child Survival Funds = $1.1 Million

Total FY 90 Population Account Funds $1,450,000

Total FY90 Obligations of FAA SEC 104 Funds = $2,450,000

Notes:

1. All Funds for the OYB component will be obligated in a Project Grant Agreement by July or August, 1990.
2. All funds under components II and III will be obligated by AID/W as Add Ons to central contracts or Buy Ins to central Cooperative Agreements. USAID/B/HHR will draft five (5) PIO/Ts for submission to AID/W by the June 28, 1990 deadline.
3. Items I. D. ii and II. F. will be done by OYB transfer.
4. HHR will draft 2 PIO/Ts for 2 local PSCs, requesting ESD/PHDC to execute 2 PSC contracts on or before 9/30/90.

The obligation plan for each successive fiscal year, FY91-94, is similar to the above plan for FY 90. The following section is a matrix of the methods of implementing and financing for each component and Table 6 on page 31 shows the proposed schedule of obligations and major implementation activities, May 1990 - September 1994. It can be seen from this chart that the number of planned obligations per fiscal year varies from 2 (FY 94) to 9 (FY 93), with an average of 5.2 obligations per year, not counting small purchases for logistics support, or approximately one PIO/T every two months.

5. Method of Implementation and Financing

The methods of implementing and financing for each component of the Project are summarized as follows:

	Component	Method of Implementation	Methods of Payment	Estimated Amount
I.	Support for GOB Activities			
	CONAPO	PGA, PILS	Advanced Pay	$ 400,000
	IBSS/CNS	PGA, PILS	Advanced Pay	$ 450,000
	MOH/MCH	PGA, PILS	Advanced Pay	$ 250,000
	AID/PMU	PIO/T, Contracts	Direct Pay	$ 312,000
	Commodities	PIO/Cs	Direct Pay	$ 155,000
	Logistical Support	Travel Authorizations Purchase Orders	Direct Pay	$ 125,000
	Evaluation/Audits	PIO/Ts Local Contracts	Direct Pay	$ 208,000
II.	Support for NGO Activities			
	Various AID/W CAs and contractors	PIO/T, buy-ins and add-ons	Direct Pay	$6,460,000
III.	Support for Social Marketing SOMARC	PIO/Ts, add-on	Direct Pay	$ 940,000
			T O T A L	$9,300,000

TABLE 6

PROPOSED SCHEDULE OF OBLIGATIONS AND MAJOR IMPLEMENTATION ACTIVITIES - (GRANTS, CONTRACTS, BUY-INS, ADD-ONS PROCUREMENT ACTIONS)

PROPOSED SCHEDULE: MAY 1990 - SEPTEMBER 1994

Activities	FY 90												FY 91												FY 92												FY 93												FY 94											
Calendar Year	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12
I. Government																																																										
a. PROAG (MOP)						x																																																			
b. PILS - MCH/MCH								x																																																	
IBSS/CNS								x																																																	
CONAPO								x																																																
c. Management Support																																																								
1. PSCs (2) contracts								x																																																
2. CC (Central procurement	(done)																																																							
3. eval./audit																																																								
4. logistical support																																																								
II. NGO Activities																																																								
Buy-Ins to: (Long-Term Activities)																																																							
a. PCS/CHU																x																																									
b. Pathfinder						x																						x																												
c. Mothercare						x																						x																												
d. Population Council																x																																							
(Medium-Term Activ.)																																																							
e. DAI						x																						x																												
f. JHPIEGO																x																																							
g. JHU/MEI	(done)															x																																							
(Short-Term Activ.																																																							
h. RAPID						x																						x																												
i. OPTIONS																x																																						
j. DHS																																																							
III. Social Marketing																																																							
a. SOMARC																x																																						

Note: For Components II and III "X" equals PIO/T for buy-in or add-on to AID/W.

5. National Coordinating Committee for the Project

In order to foster the mutual reinforcement of efforts among the various entitites participating in the Project, a National Coordinating Committee of the Project has been established by constituent agencies, which has been functioning since January 22, 1990. Voting members are: the Chief/HHR, USAID/B or his designee, the Director of the Division of Maternal-Child Health of the MOH, the Director of Gynecology services at the Hospital Obrero of IBSS, the Executive Secretary of CONAPO, the Executive Director of CIES and the PAHO Representative to Bolivia is invited as a pormanent observer. Any of these persons may send an alternate. The principal purpose of the committee is to coordinate the implementation of reproductive health activities to be carried out by all agencies involved in the Project, within the norms and regulations of the GOB and USAID. At present, there are five technical sub-committees corresponding to the five Project activities: Services; Training; Research and Evaluation; Information, Education, and Communications; and Policy Development. During the initial phase of implementation these five subcommittees will be merged into three: Services/Training; Information, Education, and Communications; Research, Education, and Policy Development. Membership on the sub-committees will be composed of technical representatives of participating organizations concerned with each technical area. The Cooperating Agencies and contractors which provide technical assistance on each subject will also be members of the corresponding sub-committee. The Memorandum of Understanding regarding the National Coordinating Committee is included as Annex L of this paper.

B. Financial Plan

The financial plan for this Project is shown below in three Tables: (1) Summary of Total Obligations by Component, (2) AID Obligations and GOB Contributions by Subcomponent, and (3) Life of Project Summary Cost Estimates by Subcomponent by Year. Additional Budget tables are shown in Annex H. The total AID dollar cost of the Reproductive Health Services Project is $9.3 million. Of this total, $7.3 million is drawn from the Population Account and $2.0 million is drawn from the Child Survival Account.

The GOB will contribute the local currency equivalent of $1.348 million through regular budget support of the Ministry of Health, IBSS/CNS and CONAPO, including $360,000 worth of local currency generated under ESF local currency generations for additional activities of CONAPO.

USAID Disbursement Procedures for GOB Sub-Components

The disbursement procedures include measures to assure the systematic and timely flow of project funds. The procedures will provide for advance payment of AID and counterpart local currency funds to be deposited into separate bank accounts to be maintained by CONAPO, IBSS/CNS and MOH/MCH.

These organizations will submit a twelve (12) month Financial Plan by quarters setting forth the costs in local currency and their equivalent in US$ by items. They will be responsible for disbursing funds in accordance with quarterly budget approvals by USAID. Also, they will submit an Operational Plan containing all information necessary to implement the Project. As a minimum it should include: 1) a procurement schedule of goods and services by source of funding (AID and GOB funds) and, 2) a reasonable justification of such procurements. AID dollar payment under the Direct Account is described in Section C. Procurement Plan.

Detailed guidelines for these procedures will be provided by USAID in PILS following Project initiation.

AID funds for the project will be channelled as indicated in Sect. 5, pg. 30, Method of Implementation and Financing.

TABLE 7

SUMMARY OF OBLIGATIONS BY MAJOR COMPONENT

	A.I.D. Contribution TOTAL ($ millions)
1. Support of GOB activities and management support	1.90
2. Support of NGO activities	6.46
3. Suppport of Social Marketing	.94
TOTAL	9.30

AID/W (S&T) may contribute additional central funds to Cooperating Agencies working in Bolivia during the life of this Project. Because the availability of these funds is conjectural, no figures can be given for these possible contributions.

TABLE 8

AID AND GOB CONTRIBUTIONS BY SUBCOMPONENT
($ 000)

COMPONENT	TOTAL A.I.D. CONTRIBUTION	% TO GOB	AID CONTRIBUTION TO GOB	GOB CONTRIBUTION	GOB CONTRIBUTION FROM ESF	TOTAL GOB CONTRIBUTION
I. GOB				$US		
a. MOH/MCH	250	100	250	117	0	117
b. IHSS/CHS	450	100	450	871	0	871
c. CONAPO	400	100	400	0	360	360
d. Management Support						
1. AID PMU	312	40	124			
2. Audit & Evaluation	208	25	52			
3. Commodities	155	30	46			
4. Logistic Support	125	0	0			
	1,900		1,322			
II. NGO						
a. JHU/PCS	1,788	10	178			
b. Pathfinder	1,000	30	300			
c. Mothercare	700	0	0			
d. Pop Council	700	15	105			
e. DAI	350	10	35			
f. JHPIEGO	500	20	100			
g. MSH/PIVOT	500	10	50			
h. TVG-RAPID	450	40	180			
i. TVG - OPTIONS	172	20	34			
j. IHS	300	50	150			
	6,460					
III. SOCIAL MARKETING (SMG)	940					
	9,300		2,454	988	360	1,348

The GOB must contribute 25% of the estimated $4,000,000 cost of project components or activities which involve direct assistance to the GOB, or at least $1,000,000. This requirement is exceeded by GOB budgetary and in-kind contributions of $988,000 and $360,000 in local currency from ESF accounts, totalling $1,348,000. The 25% contibution requirement of FAA Section 110 is not applicable to NGO activities not funded through obligations to the Government (HB) AP.2G.)

TABLE 9

LIFE OF PROJECT SUMMARY COST ESTIMATES AID AND GOB FUNDS

(IN US$)

COMPONENTS	AID GRANT			GOB	GRAND
	FX	L/C	TOTAL	L/C	TOTAL
I. SUPPORT FOR GOB ACTIVITIES	528,300	1,371,700	1,900,000	1,348,000	3,248,000
1. CONAPO	24,800	375,200	400,000	360,000	760,000
2. IBSS/CNS	102,500	347,500	450,000	871,000	1,321,000
3. MOH/MCH	71,000	179,000	250,000	117,000	367,000
4. Management Support	330,000	470,000	800,00		800,000
II. SUPPORT FOR NGO ACTIVITIES	6,460,000		6,460,000		6,460,000
1. JHU/PCS	1,788,000		1,788,000		1,788,000
2. Pathfinder	1,000,000		1,000,000		1,000,000
3. Mothercare	700,000		700,000		700,000
4. Population Council	700,000		700,000		800,000
5. Development Associates	350,000		350,000		350,000
6. JHPIEGO	500,000		500,000		500,000
7. MSH/PPMT	500,000		500,000		500,000
8. TFG - Rapid III	450,000		450,000		450,000
9. TFG - Options	172,000		172,000		172,000
10. IPD - DHS	300,000		300,000		300,000
III. CONTRACEPTIVE SOCIAL MARKETING	940,000		940,000		940,000
1. TFG - SOMARC	940,000		940,000		940,000
TOTAL	**7,928,300**	**1,371,700**	**9,300,000**	**1,348,000**	**10,648,000**

FINANCING REPRODUCTIVE HEALTH CARE IN BOLIVIA

The financial needs of the program in Bolivia are being met generally by donor community. This is likely to continue into the foreseeable future. This grant meets public and private sector needs not being covered by the GOB or other donors. On the question of reproductive health expenditures, USAID/B believes that at this time and for the near future, strategies for cost containment and use of private sector providers and distribution channels are a more viable response under AID's financing guidelines than is a premature emphasis on cost recovery.

C. Procurement Plan

The procurement plan for the Project is explained by the two Tables Nos. 5 and 6 given above under the Implementation Plan for FY 90 obligations and the schedule of major implementation activities, 1990 - 94. No significant procurement is planned under the GOB component. For Component II (NGO) and Component III (SMP), USAID/B will procure the services of eleven cooperating agencies and contractors by signing PIO/Ts for buy-ins and add-ons to AID/W central cooperative agreements and contracts under S&T/POP and S&T/Health central projects. If a central project and its contract or cooperative agreement expires, USAID/B will procure similar services from the follow-on central project. These buy-ins and add-ons will cause no significant management burden for USAID/B, because AID/W will perform procurement and accounting for these subcomponents. Normally, AID/W requires a one or two page PIO/T for these procurement actions, and simply adds the funds available in PIO/Ts from USAIDs, without any additional text, because each central cooperative agreement or contract already has a detailed scope of work and budget. Accessing these central projects is a very easy procedure for USAID/B/HHR. Additionally, eight of the eleven cooperating agencies and contractors proposed to be funded under this Project are already functioning in Bolivia, mainly with AID funding through central cooperative agreements and contracts.

Similarly, Project-funded contraceptives will be procured through the AID/W procurement system; S&T/POP/CPSD will assist the Mission in determining types, quantities, and delivery dates needed. USAID will send proforma PIO/Cs to AID/W. Shipment, delivery and distribution may be through the GOB/MOH, or a CA experienced in this field, such as Pathfinder or SOMARC.

Except for commodities, all management/logistical procurement will be handled by USAID/B by direct contracts under the FAR and AIDAR. The two Bolivian PSCs will be selected utilizing the simplified procedures stated in the AIDAR and class justification for PSCs. Logistical support (project communications) will be procured through small purchase procedures (FAR Part 13) where the value of goods or services is $25,000 or less. Contracts for audits or evaluations over $25,000 in value shall be competed under Part 15 of

the FAR. There is no construction planned under this project. The authorized geographic codes for the Project are 000 (United States of America) and the cooperating country (Republic of Bolivia). The standards and procedures to be followed in the procurement of goods and services will be those of Handbooks 1B, 11, 14 and 15.

D. Gray Amendment

Development Associates, a US minority-owned firm, will provide technical and financial assistance to the Bolivian organizations participating in the Project.

In addition, the Development Group, Inc. (DGI), a minority-owned firm, will be subcontracted by The Futures Group to develop and implement the uniform MIS for service delivery organizations.

V. COVENANTS AND CONDITIONS

The Project Grant Agreement (PGA) signed with the GOB will grant permission to the Cooperating Agencies and Contractors involved in the Project to maintain offices and staff in Bolivia in order to operate here and implement the Project. Imported Project goods will be tax-exempt. The standard covenants required for Family Planning projects under Section 104 (f) of the Foreign Assistance Act, the current appropriations act, and P.D.-3, dealing with voluntarism, abortion and sterilization, will be covenants to the PGA.

The covenants listed in the draft Authorization contain the prohibitions concerning abortion and sterilization required by FAA 104 (f) and Policy Determination-3. The last convenant, that all funds shall be used in accordance with AID population policy, is intended to incorporate all proscriptions in the current year appropriations legislation, as well as any future changes in FAA 104 or AID population policy. Since language in the appropriation bills changes from year to year, USAID has not included additional proscriptions from the FY 90 Appropriations Act in the draft Authorization.

VI. PROJECT ANALYSES SUMMARIES

ECONOMIC ANALYSIS

A benefit cost analysis was not undertaken for this project as it was strongly felt that an economic rationale for the project would weaken the case for it as far as the GOB is concerned: economic arguments are rejected by those opposed to family planning on religious or political grounds. This

project is justified by virtue of the many health benefits that would accrue to both mothers and children as a result of family planning and better child spacing. The major benefit will be a reduction in the abortion rate and of the complications resulting from them.

The major implementors of this project will be the AID/W Cooperating Agencies, Bolivian private sector reproductive health and training organizations, the Bolivian Social Security Institute, and the Ministry of Public Health (in areas where the PRONIMA III project is not operating). We believe this to be the only feasible alternative, given current political constraints.

(The Reproductive Health Services Project Economic Analysis is given in Annex E).

FINANCIAL ANALYSIS

1. Sustainability of the Services Activities

As reproductive health programs are oriented to provide services and contraceptives to low-income social groups, it has been the experience in many countries that such programs cannot be initially funded by the beneficiaries, and that appreciable recurrent costs must be borne by contributions from other sources for a relatively long period. In order to have self-sustaining reproductive health activities, the target populations would have to be in the middle and upper socio-economic levels, which are not the target groups for USAID assistance. Given current GOB budgetary constraints, it is anticipated that USAID will have to help defray recurrent expenses over the life of this project. The Project management team and TA will work with Project organizations to gradually increase income from other sources, to be conscious of costs, to account carefully for costs, and to be able to analize their cost-effectiveness in delivering selected reproductive health services.

The service providers being directly supported by the Project are expected to be able to continue to provide the level of services achieved during the course of the Project with decreased levels of USAID support after this project. Service organizations which may be added to the Project also will have to demonstrate how they are likely to be able to maintain the level of services achieved after the completion of USAID's support.

However, the prospect of achieving full cost recovery varies among the participating local organizations. The prospects for several organizations follows:

IBSS — Given the method of financing of the IBSS system, the existence of its infrastructure throughout the country, the relatively low marginal cost to the system of increasing the coverage of the maternal health program, and the probable savings in costs from less hospitalizations for abortion complications among the insured population, it is possible that the program can achieve financial self-sustainability within five years.

CIES — It is expected that enough income will be generated by users fees to increase the coverage of operating expenses from 10% in 1989 to 29% in 1993. The gap will need to be supplied by external assistance institutions. CIES has higher costs than SERVIFAM because of the level of its involvement in research and training activities.

FUNDACION SAN GABRIEL — According to reported financial data, FSG, with all its services included, is reaching now around 45% of self-sustainability, while the main Hospital reaches 70%. The expected rate of increase in recuperations is of 2.5% to 3% annually. The remainder of the funding is currently being provided through outside assistance mainly from German churches and foundations. According to the Director, these contributions are expected to decrease in the future.

PROSALUD — PROSALUD's program is an experiment in the self-financing of a primary health care program in Santa Cruz. The reproductive health component should follow the same pattern. PROSALUD currently is generating revenues equal to around 90% of the direct costs of the provision of services without including a contribution of 20% of the cost of its central office. The remaining 80% of the central office costs have to be covered by central office activities such as consultant services, training, educational materials and FP services. Since reproductive health activities are now a small part of PROSALUD's overall program, PROSALUD's prospects of increasing its financial sustainability are good.

SERVIFAM — SERVIFAM currently is generating services to cover around 12% of its total operating expenses. This figure is expected to reach 56% in 1993. SERVIFAM's main sources of income are fees paid by users, private and governmental support and some external assistance. The prospects are that all these sources will continue to provide support to SERVIFAM so it can be assumed that it would be able to continue to provide services after the Project ends.

SOMARC — The social marketing program is expected to be self-sufficient after the low-dose orals, condoms and IUDs are added to the program. The promotion and awareness campaigns should be continued by ABENDROTH after the Project, but they probably will be at a lower level as the market should have been developed during the life of the Project.

2. Institutional Analysis

The capacity of the organizations participating in the Project to manage funds is addressed in the institutional analyses. It appears that many of these organizations will need support in the financial management

area. The Project provides support for the central Family Planning Management Training project (MSH) to provide technical assistance and training to the organizations on the specialized aspects of financial management as part of the Training component. With technical assistance provided by MSH/FPMT to all of the local organizations participating in the Project, the financial management of the Project's resources should not present a problem.

SOCIAL ANALYSIS

If the Reproductive Health Services Project objectives are achieved, the social welfare of children and mothers in Bolivia will be enhanced. Reductions of high risk pregnancies (high parity and short-interval births) and improved MCH service delivery will not only lower maternal and childhood morbidity and mortality, but will reduce the fatalism many women currently attach to their own health prospects and overall social status.

The social feasibility of this Project depends on being able to educate the target populations about the health benefits of reproductive health. Several factors have been put forward to explain the low acceptance of family planning in Bolivia. Generally, they are based on macho attitudes, poor health conditions and ignorance. In order to overcome these barriers, the Project will have to break down traditional beliefs and promote attitudinal changes through working with the existing community structures and providing sex education, reproductive health promotion and services. Providers will have to address both language and cultural barriers when working in the communities. Although the Project targets mainly the urban population, many persons in that population still adhere to traditional attitudes and behaviour.

(The Reproductive Health Services Project Social Analyses is given in Annex F).

WOMEN IN DEVELOPMENT

Reproductive Health Care plays an integral part in raising the status of women. In this Project, reproductive health serves as a tool for promoting better health for women and children. Improving women's health status will increase their economic opportunities. At the same time, reproductive health provides women with a means of controlling their fertility and reducing their dependence on abortion. Raising the level of consciousness may prompt women to challenge the traditional, macho attitudes that tend to influence Bolivian thought.

The IEC activities included in the Project will provide the public with information on the health benefits of reproductive health. Educational materials about reproductive health will be available in clinics and will allow women to make an informed decision about contraception. Talks given to mothers' clubs and similar organizations will provide women with knowledge about reproductive health and sex education. During the later years of the

Project, mass media campaigns will be undertaken. The campaigns will emphasize the health benefits of reproductive health and promote the status of women.

Several training opportunities will also be made available to women through the Project. Volunteer promoters are one of the primary vehicles for service delivery. Promoters generally are women from the community who are trained to provide information about reproductive health and distribute methods. Within the family planing organizations, training will be provided for medical and paramedical staff, administrators and educators. Since a large proportion of those working with reproductive health organizations are women, many opportunities will exist for women to improve their skills level.

It would be difficult to discuss reproductive health without considering how it affects the status of women. This project addresses improving the status of women by providing them with education, training, and the opportunity to decide freely as to the number and spacing of children they will have.

INSTITUTIONAL/TECHNICAL ANALYSIS

During the Reproductive Health Services Project, USAID will be directly concerned with administrative efficiency in the following institutional settings: (1) Various Units of the GOB, including: (a) high level support for the Reproductive Health program; (b) the need for improved management practices, full staffing, and professional and technical training. (2) Coordination and collaboration of all program activities beetween GOB, PVOs and Social Marketing. (3) Influence on program decisions by various research institutions, which, in turn, can influence administrative and policy decisions.

(The Reproductive Health Institutional/technical Analysis is given in Annex G).

INITIAL ENVIRONMENTAL EXAMINATION

Generally, population, health and nutrition projects fall under 22.C.F.R Section 216 (c)(2)(viii), Categorical Exclusions, as types of projects that do not require an Initial Environment Examination or further environmental scruting. This project was so determined to be categorically excluded from the requirements for further environmental review by the LAC Bureau Deputy Environmental officer on February 23, 1989. (See Annex I).

ANNEXES

UNCLASSIFIED STATE 074681/01 ANNEX A

AID AMB DCM ECON Rec'd 3/10

VZCZCLP0982 FILE: PD&I LOC: 099 149
FF RUEHLP 10 MAR 89 2305
DE RUEHC #4681/01 0662306 CN: 10874
ZNR UUUUU ZZH CHRG: AID
P 0923022 MAR 89 DIST: AIDE
FM SECSTATE WASHDC
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ACTION: HHR 2
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REPLY DUE 3/17

E.O. 12356: N/A
TAGS: ACTION TKN
SUBJECT: EXPANSION OF CHILD SPACING SERVICES PROJECT (511-0568)

1. THE DAEC REVIEWED THE SUBJECT PID ON FEBRUARY 27, 1989. THE MISSION IS TO BE COMMENDED ON FORGING LINKS WITH THE FAMILY PLANNING SECTOR IN BOLIVIA. THE PROJECT IS APPROVED FOR FURTHER DEVELOPMENT SUBJECT TO THE FOLLOWING GUIDANCE. THE PP WILL BE SUBMITTED TO WASHINGTON FOR FINAL APPROVAL AND AUTHORIZATION.

2. CENTRAL ISSUES. THE CENTRAL ISSUES OF THE DAEC REVIEW WERE THE ADEQUACY OF THE PID DESIGN AND THE RELATIONSHIP OF THE PROPOSED PROJECT TO THE SIGNIFICANT RESOURCE COMMITMENTS BEING MADE BY S&T/POP FOR FAMILY PLANNING ACTIVITIES IN BOLIVIA.

3. PID DESIGN FOCUS - CONSIDERABLE CONCERN WAS EXPRESSED ABOUT THE LACK OF ADEQUATE ANALYSIS IN THE PID TO SUPPORT THE PROPOSED MIX OF ACTIVITIES. THE DAEC CONCLUDED THAT THE PID WAS NOT SUFFICIENTLY FIRM TO WARRANT DELEGATION TO APPROVE THE PP IN THE FIELD. THE PID, GIVEN ITS WIDE RANGE OF PROPOSED ACTIVITIES, DID NOT ARTICULATE THE MISSION'S PRIORITIES IN THE POPULATION SECTOR. THE PP WILL CAREFULLY CONSIDER, IN LIGHT OF REAL FUNDING ISSUES, A FOCUS ON CORE ELEMENTS OF THE PROJECT WHERE FIRM PROPOSALS ARE AVAILABLE TO THE MISSION. THE PP SHOULD CONTAIN A CLEAR INDICATION OF THE TARGET POPULATIONS ASSOCIATED WITH A PARTICULAR TYPE OF ELEMENT. THE MISSION IS ALSO URGED TO PUT ON THE SHELF THOSE ACTIVITIES WHICH MIGHT BE CONSIDERED HELPFUL BUT NOT URGENTLY NEEDED AND BEYOND THE CAPACITY OF THE MISSION TO ADEQUATELY MANAGE.

4. ROLE OF S&T POPULATION FUNDING IN BOLIVIA- IT WAS NOTED THAT THE PROJECT WAS PROPOSING FUNDING FOR A NUMBER OF POPULATION ACTIVITIES ALREADY FUNDED BY S&T/POP. FYI S&T REPORTS THAT OVERALL FY 89 LEVELS , INCLUDING CA OVERHEAD RELATED TO BOLIVIA, WILL EXCEED DOLS TWO MILLION END FYI. THE PP WILL PROVIDE A CLEAR ANALYSIS OF THE ADDITIONAL RESOURCES THIS PROJECT WILL

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BRING TO BEAR ON THE FAMILY PLANNING PROBLEM AS WELL AS THE RATIONALE FOR INITIATING THE PROJECT GIVEN THE ONGOING SUPPORT FOR FAMILY PLANNING BY THE S&T BUREAU.

4.THE PP WILL ALSO CONTAIN THE FOLLOWING INFORMATION:

A) THE GOAL AND PURPOSE STATEMENT SHOWN IN THE PID WILL BE MODIFIED IN THE PP. THE PURPOSE OF THE PROJECT WILL BE TO INCREASE ACCESS TO VOLUNTARY FAMILY PLANNING SERVICES. THE GOAL OF THE PROJECT WILL BE TO IMPROVE MATERNAL AND CHILD HEALTH. THE MISSION WILL MODIFY THE INDICATORS AND MEANS OF VERIFICATION IN THE LOGFRAME ACCORDINGLY.

B) THE PP WILL REVIEW THE STATE OF SERVICE DELIVERY IN THE PUBLIC AND PRIVATE SECTORS I.E. WHAT ARE THE INSTITUTIONS DOING NOW AND WHAT WILL THEY BE DOING UNDER THE PROPOSED PROJECT. IT WILL ALSO EVALUATE THE SIZE OF THE CENTRALLY FUNDED POPULATION PORTFOLIO IN BOLIVIA AT THE PRESENT AND WHAT EXPECTED RESOURCES AND ACTIVITIES WILL BE IMPLEMENTED DURING THE LIFE OF PROJECT.

C) THE PP WILL INCLUDE A MANAGEMENT ASSESSMENT OF ALL INSTITUTIONS TO RECEIVE FUNDING UNDER THE PROJECT NOTING THEIR STRENGTHS AND WEAKNESSES IN ORDER TO ASSESS WHAT SHOULD BE THE APPROPRIATE SIZE AND MIX OF INSTITUTIONS UNDER THE PROJECT AND WHAT INTERVENTIONS MIGHT BE NEEDED TO STRENGTHEN MANAGEMENT CAPABILITY. THE PP SHOULD CLEARLY SET FORTH SUSTAINABILITY OBJECTIVES FOR INSTITUTIONS TO BE INVOLVED IN THE PROJECT NOTING WHICH INSTITUTIONS ARE EXPECTED TO BECOME SELF-SUSTAINING AND WHICH INSTITUTIONS ARE ESSENTIALLY ONLY EXPECTED TO PROVIDE SERVICES OVER THE NEAR TERM.

D) THE PP WILL INCLUDE A FINANCIAL ANALYSIS SECTION WHICH WILL INCLUDE, AMONG OTHER THINGS, RECURRENT COST ANALYSES OF ALL INSTITUTIONS TO RECEIVE PROJECT FUNDS AND AN ASSESSMENT OF COUNTERPART CONTRIBUTIONS TO BE PROVIDED UNDER THE PROJECT. THE PP SHOULD SHOW THAT THE PROJECT WILL ACHIEVE THE STATED OBJECTIVES AT THE LEAST COST POSSIBLE. THE PP WILL THUS CONTAIN A COST EFFECTIVENESS ANALYSIS.

E) THE PP SHOULD INCLUDE AN ECONOMIC ANALYSIS OF THE PROJECT DEALING SPECIFICALLY WITH THE BOLIVIA CASE.

F) ALTHOUGH THE PID INDICATES THAT A CONTRACTOR WOULD BE RESPONSIBLE FOR BUY-INS AND OVERALL MANAGEMENT OF PROJECT RESOURCES, THE MISSION APPARENTLY IS CONSIDERING A DIFFERENT APPROACH. CURRENT THINKING IS FOR THE CONTRACTOR TO PROVIDE MANAGEMENT SUPPORT AND

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COORDINATION ASSISTANCE TO THE MISSION. THE PP MUST ADDRESS THE IMPLEMENTATION ALTERNATIVES CLEARLY DEFINING THE ROLE OF THE CONTRACTOR AND MISSION IN PROJECT IMPLEMENTATION. LAC/DR WILL PROVIDE THE MISSION WITH A REVIEW OF DIFFERENT MODALITIES USED IN OTHER MISSIONS FOR POPULATION PROJECT IMPLEMENTATION.

G) AS THE PID SUGGESTS THAT THE PROJECT MAY PROVIDE FAMILY PLANNING SERVICE SUPPORT TO THE BOLIVIAN ARMY, THE MISSION SHOULD ASSURE ITSELF, WITH RLA ASSISTANCE, THAT SUCH SUPPORT IS CONSISTENT WITH EXISTING LEGISLATION. BAKER

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ANNEX B
LOGICAL FRAMEWORK

PROJECT DESIGN SUMMARY

Project Title & Number: Reproductive Health Services 511-0568

Life of Project: From FY 90 to FY 94
Total U.S. Funding $9,300,0000
Date Prepared: 4/30/90

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
Program or Sector Goal:	Measures of Goal Achievement		Assumptions for Achieving Goal Targets
To improve maternal and child health in Bolivia	Infant Mortality Rate reduced from 102/1000 live births	1993 Demographic and Health Survey (DHS)	The women will who accept family planning methods are in high risk groups
	Maternal Mortality Rate reduced from 48/10,000 live births	1993 DHS	
	Proportion of women hospitalized for abortion reduced from 48% in 1988 in IBSS facilities	IBSS and MOH records	USAID's assessment that there is high unmet demand for reproductive health services
	Proportion of closely-spaced births (less than 24 mos. apart) reduced from 42% to 32%	Service Statistics, 1993 DHS	Political and economic conditions will not deteriorate
Project Purpose:	Conditions that will indicate Purpose has been achieved: End of Project Status		Assumptions for Achieving Purpose
To increase the access and quality of reproductive health care services in Bolivia	1. Contraceptive* prevalence increases from 12% to 17% nationwide among married women in fertile ages (MWRA), and is higher than the nat'l average in target areas (La Paz, Santa Cruz, and Cochabamba)	1993 DHS	GOB/Church continue to accept health rationale for reproductive health services
	*includes scientific NFP methods		The GOB and PVOs will develop effective strategies for local collaboration in providing reproductive services OR will identify administrative problems, and facilitate introduction of improved systems

Project Title & Number: Reproductive Health 511-0568

Life of Project: From FY 90 to FY 94
Total U.S. Funding $9,300,0000
Date Prepared: 4/30/90

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
	2. Number of active users of family planning methods using participating service delivery mechanisms increases from 1988 levels (SOMARC contribution measured in CYP)	MIS Service statistics	
	3. Proportion of babies fully breastfed for at least 4 months does not decline	Special Study DHS	Current level of exclusive breast-feeding is adequate

Project Title & Number: Reproductive Health 511-0568

Life of Project: From FY 90 to FY 94
Total U.S. Funding $9,300,000
Date Prepared: 4/30/90

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
Outputs	Magnitude of Outputs		Assumptions for Achieving Outputs
-Increased access to reproductive health services: geographic, cultural, and financial	100% of MOH project facilities in target Health Areas with maternal and child health services include family planning services	MOH service statistics by facility Site Visits	MOH Budget restrictions do not force reduced MCH services MOH policy to provide family planning services as part of reproductive health care does not change
	80% of IBSS facilities nationwide with maternal and child health services include family planning services	IBSS service statistics, by facility Site visits	IBSS continues to collect 1% of the wage base from workers and 8.5% from employers
Increased knowledge of, and demand for, a full range of reproductive health services	100% of participating local PVOs continue to provide family planning services as part of reproductive health care	PVO technical reports to USAID	Other Child Survival projects and donors will continue to provide complementary support to activities
	100% of participating local PVOs regularly conduct community outreach activities and have outreach materials	PVO technical reports to USAID	
	100% of SOMARC outlets offer pills and condoms	SOMARC sales records, by outlet Site Visits	
	90% MWRA have knowledge of the risk factors for pregnancy, contraceptive methods, and sources of supply	1993 DHS Focus groups behavioral research	

Project Title & Number: Reproductive Health 511-0568

Life of Project: From FY 90 to FY 94
Total U.S. Funding $9,300,000
Date Prepared: 4/30/90

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
	10 % of service facilities with staff speaking local indigenous language	-Site visits	
	Prices of reproductive health services and contraceptives prices not a barrier to use	-Operations Research -Studies	
Increased quality of selected reproductive health care services	1. Service delivery norms followed	-Client records	Norms can be agreed on by National Project Coordinating Committee and MOH
	2. Voluntary choice of family planning method by client (within medical guidelines)	-PVO technical reports -Surveys -Service statistics method mix -Client records	
	3. Number and variety of family planning methods offered at each site	-Site visits -Clinic records	
	4. Acceptable waiting time in clinics	-Focus groups behavioral research	

PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

ANNEX B
Life of Project: From FY 90 to FY 94
Total U.S. Funding $9,300,000
Date Prepared: 4/30/90

Project Title & Number: Reproductive Health 511-0568

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
Inputs	Level of Expenditure ($ 000)		Assumptions for providing Inputs
USAID Provided:			
1. Various expenditures for support to GOB Reproductive Health activities	1,100	1. Internal monitoring documents	1. Procurement, training, and delivery of TA an accomplished on a timely basis
2. Funding for Cooperative Agreement and Contracts with reproductive health NGOs	7,400	2. External evaluation	2. AID funds are obligated and disbursed on a timely basis
3. Funds for local management and support activities	437	3. Project disbursement and audit reports	3. GOB and NGO resources (personnel, office space, equipment, etc.) are provided on a timely basis, and in adequate quantity
4. Funds for audits and evaluation in order to assess program performance and improve project administration	208	4. CA/Contractor reports and records	
5. Contraceptive Commodities	155	5. Project officer reports and records	
TOTAL	9,300		

Project Title & Number: Reproductive Health 511-0568

Total U.S. Funding $9,300,000
Date Prepared: 4/30/90

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
Inputs	Implementation Target (Type and Quantity)		Assumptions for providing Inputs
GOB Provided: Requisite Staff, facilities and local costs	1,348	GOB Records	GOB funds for CONAPO will be available from ESF Local Currency
PVO Provided: Necessary staff, facilities and some local costs to support CA/Contractor inputs			

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5C(1) - COUNTRY CHECKLIST

Listed below are statutory criteria applicable to: (A) FAA funds generally; (B)(1) Development Assistance funds only; or (B)(2) the Economic Support Fund only. NO

A. GENERAL CRITERIA FOR COUNTRY ELIGIBILITY

1. FY 1990 Appropriations Act Sec. 569(b). Has the President certified to the Congress that the government of the recipient country is failing to take adequate measures to prevent narcotic drugs or other controlled substances which are cultivated, produced or processed illicitly, in whole or in part, in such country or transported through such country, from being sold illegally within the jurisdiction of such country to United States Government personnel or their dependents or from entering the United States unlawfully? NO

2. FAA Sec. 481(h); FY 1990 Appropriations Act Sec. 569(b). (These provisions apply to assistance of any kind provided by grant, sale, loan, lease, credit, guaranty, or insurance, except assistance from the Child Survival Fund or relating to international narcotics control, disaster and refugee relief, narcotics education and awareness, or the provision of food or medicine.) If the recipient is a "major illicit drug producing country" (defined as a country producing during a fiscal year at least five metric tons of opium or 500 metric tons of coca or marijuana) or a "major drug-transit country" (defined as a country that is a significant direct source of illicit drugs significantly affecting the United States, through which such drugs

are transported, or through which significant sums of drug-related profits are laundered with the knowledge or complicity of the government): (a) Does the country have in place a bilateral narcotics agreement with the United States, or a multilateral narcotics agreement? and (b) Has the President in the March 1 International Narcotics Control Strategy Report (INSCR) determined and certified to the Congress (without Congressional enactment, within 45 days of continuous session, of a resolution disapproving such a certification), or has the President determined and certified to the Congress on any other date (with enactment by Congress of a resolution approving such certification), that (1) during the previous year the country has cooperated fully with the United States or taken adequate steps on its own to satisfy the goals agreed to in a bilateral narcotics agreement with the United States or in a multilateral agreement, to prevent illicit drugs produced or processed in or transported through such country from being transported into the United States, to prevent and punish drug profit laundering in the country, and to prevent and punish bribery and other forms of public corruption which facilitate production or shipment of illicit drugs or discourage prosecution of such acts, or that (2) the vital national interests of the United States require the provision of such assistance?

yes

yes

no

3. 1986 Drug Act Sec. 2013. (This section applies to the same categories of assistance subject to the restrictions in FAA Sec. 481(h), above.) If recipient country is a "major illicit drug producing country" or "major drug-transit country" (as defined for the purpose of FAA Sec 481(h)), has the President submitted a report to

Congress listing such country as one: (a) which, as a matter of government policy, encourages or facilitates the production or distribution of illicit drugs; (b) in which any senior official of the government engages in, encourages, or facilitates the production or distribution of illegal drugs; (c) in which any member of a U.S. Government agency has suffered or been threatened with violence inflicted by or with the complicity of any government officer; or (d) which fails to provide reasonable cooperation to lawful activities of U.S. drug enforcement agents, unless the President has provided the required certification to Congress pertaining to U.S. national interests and the drug control and criminal prosecution efforts of that country?

no

no

no

no

4. 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?

no

5. FAA Sec. 620(e)(1). If assistance is to a government, has it (including any government agencies or subdivisions) taken any action which has the effect of nationalizing, expropriating, or otherwise seizing ownership or control of property of U.S. citizens or entities beneficially owned by them without taking steps to discharge its obligations toward such citizens or entities?

no

6.	FAA Secs. 620(a), 620(f), 620D; FY 1990 Appropriations Act Secs. 512, 548. 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, South Yemen, 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?	no
7.	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?	no
8.	FAA Sec. 620(l). Has the country failed to enter into an investment guaranty agreement with OPIC?	no
9.	FAA Sec. 620(o); Fishermen's Protective Act of 1967 (as amended) Sec. 5. (a) Has the country seized, or imposed any penalty or sanction against, any U.S. fishing vessel because of fishing activities in international waters? (b) If so, has any deduction required by the Fishermen's Protective Act been made?	(N/A as Bolivia is landlocked)

10. FAA Sec. 620(q); FY 1990 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? no
(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? no

11. 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.) (N/A, as this project is DA-funded)

12. 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

13. FAA Sec. 620(u). What is the payment status of the country's U.N. obligations? If the country is in arrears, were such arrearages taken into account by the A.I.D. Administrator in determining the current A.I.D. Operational Year Budget? (Reference may be made to the "Taking into Consideration" memo.) Not in arrears

14. FAA Sec. 620A. Has the President determined that the recipient country grants sanctuary from prosecution to any individual or group which has committed an act of international terrorism or otherwise supports international terrorism? no

15. FY 1990 Appropriations Act Sec. 564. 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? no

16. ISDCA of 1985 Sec. 552(b). Has the Secretary of State determined that the country is a high terrorist threat country after the Secretary of Transportation has determined, pursuant to section 1115(e)(2) of the Federal Aviation Act of 1958, that an airport in the country does not maintain and administer effective security measures? no

17. FAA Sec. 666(b). Does the country (no) object, on the basis of race, religion, national origin or sex, to the presence of any officer or employee of the U.S. who is present in such country to carry out economic development programs under the FAA? no

18. FAA Secs. 669, 670. Has the country, after August 3, 1977, delivered to any other country or received nuclear enrichment or reprocessing equipment, materials, or technology, without specified arrangements or safeguards, and without special certification by the President? Has it transferred a nuclear explosive device to a non-nuclear weapon state, or if such a state, either received or detonated a nuclear explosive device? (FAA Sec. 620E permits a special waiver of Sec. 669 for Pakistan.) no

19. FAA Sec. 670. If the country is a non-nuclear weapon state, has it, on or after August 8, 1985, exported (or attempted to export) illegally from the United States any material, equipment, or technology which would contribute significantly to the ability of a country to manufacture a nuclear explosive device? — no

20. 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.) — yes; yes, in the memo

21. FY 1990 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? — no

22. FY 1990 Appropriations Act Sec. 539. 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

B. FUNDING SOURCE CRITERIA FOR COUNTRY ELIGIBILITY

1. Development Assistance Country Criteria

a. 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? (no)

b. FY 1990 Appropriations Act Sec. 535. 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? (no)

2. Economic Support Fund Country Criteria

c. 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? (no)

d. FY 1990 Appropriations Act Sec. 569(d). Has this country met its drug eradication targets or otherwise taken significant steps to halt illicit drug production or trafficking? (yes)

5C(2) - PROJECT CHECKLIST

Listed below are statutory criteria applicable to projects. This section is divided into two parts. Part A includes criteria applicable to all projects. Part B applies to projects funded from specific sources only: B(1) applies to all projects funded with Development Assistance; B(2) applies to projects funded with Development Assistance loans; and B(3) applies to projects funded from ESF.

(yes)

(yes)

(not required)

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

A. GENERAL CRITERIA FOR PROJECT

1. FY 1990 Appropriations Act Sec. 523; 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? (yes)

2. 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? (yes)

3. 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 the assistance? (not required)

4.	FAA Sec. 611(b); FY 1990 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 the principles, standards, and procedures established pursuant to the Water Resources Planning Act (42 U.S.C. 1962, et seq.)? (See A.I.D. Handbook 3 for guidelines.)	
5.	FAA Sec. 611(e). If project is capital assistance (e.g., construction), and total U.S. assistance for it will exceed $1 million, has Mission Director certified and Regional Assistant Administrator taken into consideration the country's capability to maintain and utilize the project effectively?	N/A
6.	FAA Sec. 209. Is project susceptible to execution as part of regional or multilateral project? If so, why is project not so executed? Information and conclusion whether assistance will encourage regional development programs.	Parts of the project will be executed through regional health and population projects
7.	FAA Sec. 601(a). Information and conclusions on whether projects will encourage efforts of the country to:	
	(a) increase the flow of international trade;	(no)
	(b) foster private initiative and competition;	(yes)
	(c) encourage development and use of cooperatives, credit unions, and savings and loan associations;	(no)
	(d) discourage monopolistic practices;	(no)
	(e) improve technical efficiency of industry, agriculture and commerce; and	(yes)
	(f) strengthen free labor unions.	(no)
8.	FAA Sec. 601(b). Information and conclusions on how project will encourage U.S. private trade and investment abroad and encourage private U.S. participation in foreign assistance programs (including use of private trade channels and the services of U.S. private enterprise).	Several private U.S. contractors will work on the project

9. FAA Secs. 612(b), 636(h). Describe steps taken to assure that, to the maximum extent possible, the country is contributing local currencies to meet the cost of contractual and other services, and foreign currencies owned by the U.S. are utilized in lieu of dollars.	The GOB will contribute local currency equal to 25% of the cost of the GOB components of the Project
10. FAA Sec. 612(d). Does the U.S. own excess foreign currency of the country and, if so, what arrangements have been made for its release?	(no)
11. FY 1990 Appropriations Act Sec. 521. If assistance is for the production of any commodity for export, is the commodity likely to be in surplus on world markets at the time the resulting productive capacity becomes operative, and is such assistance likely to cause substantial injury to U.S. producers of the same, similar or competing commodity?	N/A
12. FY 1990 Appropriations Act Sec. 547. Will the assistance (except for programs in Caribbean Basin Initiative countries under U.S. Tariff Schedule "Section 807," which allows reduced tariffs on articles assembled abroad from U.S.-made components) be used directly to procure feasibility studies, prefeasibility studies, or project profiles of potential investment in, or to assist the establishment of facilities specifically designed for, the manufacture for export to the United States or to third country markets in direct competition with U.S. exports, of textiles, apparel, footwear, handbags, flat goods (such as wallets or coin purses worn on the person), work gloves or leather wearing apparel?	(no)
13. FAA Sec. 119(g)(4)-(6) & (10). Will the assistance: (a) support training and education efforts which improve the capacity of recipient countries to prevent loss of biological diversity;	(no)
(b) be provided under a long-term agreement in which the recipient country agrees to protect ecosystems or other	(no)

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? (no) (no)

14. FAA Sec. 121(d). If a Sahel project, has a determination been made that the host government has an adequate system for accounting for and controlling receipt and expenditure of project funds (either dollars or local currency generated therefrom)? N/A

15. FY 1990 Appropriations Act, Title II, under heading "Agency for International Development." 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? (yes)

16. FY 1990 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.? (yes)

17. FY 1990 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

18. State Authorization Sec. 139 (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 the agreement been pouched to those same offices? (See Handbook 3, Appendix 6G for agreements covered by this provision).	These actions will be taken after the project grant agreement is signed
19. Trade Act Sec. 5164 (as interpreted by conference report), amending Metric Conversion Act of 1975 Sec. 2. Does the project 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, subassemblies, and semi-fabricated materials to be specified in metric units when economically available and technically adequate?	Metric measurements will be used for procurement of some of the family planing commodities purchased under the project, e.g. condoms and pils
20. FY 1990 Appropriations Act, Title II, under heading "Women in Development." Will assistance be designed so that the percentage of women participants will be demonstrably increased?	(yes)
21. FY 1990 Appropriations Act Sec. 592(a). If assistance is furnished to a foreign government under arrangements which result in the generation of local currencies, 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?	Local currencies will not be generated under this project. However, the GOB will contribute LC for costs of the GOB component

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? N/A

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?

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?

B. FUNDING CRITERIA FOR PROJECT

1. Development Assistance Project Criteria

a. FY 1990 Appropriations Act Sec. 546 (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, 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?	N/A
b. 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)?	N/A
c. 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 governmental and political processes essential to self-government.	The project seeks to develop and satisfy the demand for quality family planning services develop the capacity of local institutions an deliver such services, a train service providers

d. 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?	(yes)
e. FAA Secs. 102(b), 111, 113, 281(a). Describe extent to which activity will: (1) 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; (2) help develop cooperatives, especially by technical assistance, to assist rural and urban poor to help themselves toward a 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 of women's status; and (5) utilize and encourage regional cooperation by developing countries.	(1) The project will improve accessto F.P. services at the Local level, thereby (2) Raising local Health standards (3) By supportin local F.P. organizations through small grants (4) many of whose members are women (5) Who are receptive to regional cooperation
f. FAA Secs. 103, 103A, 104, 105, 106, 120-21; FY 1990 Appropriations Act, Title II, under heading "Sub-Saharan Africa, DA." Does the project fit the criteria for the source of funds (functional account) being used?	(yes)
g. FY 1990 Appropriations Act, Title II, under heading "Sub-Saharan Africa, DA." Have local currencies generated by the sale of imports or foreign exchange by the government of a country in Sub-Saharan Africa from funds appropriated under Sub-Saharan Africa, DA been deposited in a special account established by that government, and are these local currencies available only for	N/A

use, in accordance with an agreement with the United States, for development activities which are consistent with the policy directions of Section 102 of the FAA and for necessary administrative requirements of the U. S. Government?	
h. FAA Sec. 107. Is emphasis placed on use of appropriate technology (relatively smaller, cost-saving, labor-using technologies that are generally most appropriate for the small farms, small businesses, and small incomes of the poor)?	yes, condoms and pills
i. 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, for COB-components
j. 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
k. FAA Sec. 281(b). Describe extent to which program recognizes the particular needs, desires, and capacities of the people of the country; utilizes the country's intellectual resources to encourage institutional development; and supports civil education and training in skills required for effective participation in governmental processes essential to self-government.	The project seeks to expand the availability of quality F.P. services through the development of local F.P. service organizations
l. FY 1990 Appropriations Act, under heading "Population, DA," and Sec. 535. Are any of the funds to be used for the performance of abortions as a method of family planning or to motivate or coerce any person to practice abortions?	no.

Are any of the funds to be used to pay for the performance of involuntary sterilization as a method of family planning or to coerce or provide any financial incentive to any person to undergo sterilizations?	(no)
Are any of the funds to be made available to any organization or program which, as determined by the President, supports or participates in the management of a program of coercive abortion or involuntary sterilization?	(no)
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)
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)
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)
m. FAA Sec. 601(e). Will the project utilize competitive selection procedures for the awarding of contracts, except where applicable procurement rules allow otherwise?	yes
n. FY 1990 Appropriations Act Sec. 579. 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	5-10%

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)?	
o. FAA Sec. 118(c). Does the assistance comply with the environmental procedures set forth in A.I.D. Regulation 16? Does the assistance place a high priority on conservation and sustainable management of tropical forests? Specifically, does the assistance, to the fullest extent feasible: (1) stress the importance of conserving and sustainably managing forest resources; (2) support activitie 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	yes Family planning activites are categorically excluded from the requirement of AID Regulation 16 under 22 C.F.R. Sec. 216.2 (c)(2)(viii) N/A - this is not a Forestry Project

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 donors of the immediate and long-term value of tropical forests; and (11)/utilize the resources and abilities of all relevant U.S. government agencies?

p. FAA Sec. 118(c)(13). If the assistance will support a program or project significantly affecting tropical forests (including projects involving the planting of exotic plant species), will the program or project: (1) be based upon careful analysis of the alternatives available to achieve the best sustainable use of the land, and (2)/take full account of the environmental impacts of the proposed activities on biological diversity? N/A

q. FAA Sec. 118(c)(14). 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; or (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? (no) (no)

r. FAA Sec. 118(c)(15). Will assistance be used for: (1) activities which would result in the conversion of forest lands to the rearing of livestock; (2) the construction, upgrading, or maintenance of roads (including temporary haul roads for logging or other extractive industries) which pass through relatively undergraded forest lands; (3) the (no) (no) (no)

colonization of forest lands; or (4) 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? (no)

s. FY 1990 Appropriations Act Sec. 534(a). 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 sustainable forestry? N/A

t. FY 1990 Appropriations Act Sec. 534(b). If assistance relates to energy, will such assistance focus on improved energy efficiency, increased use of renewable energy resources, and national energy plans (such as least-cost energy plans) which include investment in end-use efficiency and renewable energy resources? N/A

Describe and give conclusions as to how such assistance will: (1) increase the energy expertise of A.I.D. staff, (2) help to develop analyses of energy-sector actions to minimize emissions of greenhouse gases at least cost, (3) develop energy-sector plans that employ end-use analysis and other techniques to identify cost-effective actions to minimize reliance on fossil fuels, (4) help to analyze fully environmental impacts (including impact on global warming), (5) improve efficiency in production, transmission, distribution, and use of energy, (6) assist in exploiting nonconventional renewable energy resources, including wind, solar, small-hydro, geo-thermal, and advanced

biomass systems, (7) expand efforts to meet the energy needs of the rural poor, (8) encourage host countries to sponsor meetings with United States energy efficiency experts to discuss the use of least-cost planning techniques, (9) help to develop a cadre of United States experts capable of providing technical assistance to developing countries on energy issues, and (10) strengthen cooperation on energy issues with the Department of Energy, EPA, World Bank, and Development Assistance Committee of the OECD.

u. FY 1990 Appropriations Act, Title II, under heading "Sub-Saharan Africa, DA" (as interpreted by conference report upon original enactment). If assistance will come from the Sub-Saharan Africa DA account, is it: (1) to be used to help the poor majority in Sub-Saharan Africa through a process of long-term development and economic growth that is equitable, participatory, environmentally sustainable, and self-reliant; (2) being provided in accordance with the policies contained in section 102 of the FAA; (3) being provided, when consistent with the objectives of such assistance, through African, United States and other PVOs that have demonstrated effectiveness in the promotion of local grassroots activities on behalf of long-term development in Sub-Saharan Africa; (4) being used to help overcome shorter-term constraints to long-term development, to promote reform of sectoral economic policies, to support the critical sector priorities of agricultural production and natural resources, health, voluntary family planning services, education, and income generating opportunities, to bring about appropriate sectoral restructuring of the Sub-Saharan African economies, to support reform in public administration and finances and to establish a favorable environment for individual enterprise and self-sustaining development, and to take

N/A

into account, in assisted policy reforms, the need to protect vulnerable groups; (5) being used to increase agricultural production in ways that protect and restore the natural resource base, especially food production, to maintain and improve basic transportation and communication networks, to maintain and restore the renewable natural resource base in ways that increase agricultural production, to improve health conditions with special emphasis on meeting the health needs of mothers and children, including the establishment of self-sustaining primary health care systems that give priority to preventive care, to provide increased access to voluntary family planning services, to improve basic literacy and mathematics especially to those outside the formal educational system and to improve primary education, and to develop income-generating opportunities for the unemployed and underemployed in urban and rural areas?

v. International Development Act Sec. 711, FAA Sec. 463. If project will finance a debt-for-nature exchange, describe how the exchange will support protection of: (1) the world's oceans and atmosphere, (2) animal and plant species, and (3) parks and reserves; or describe how the exchange will promote: (4) natural resource management, (5) local conservation programs, (6) conservation training programs, (7) public commitment to conservation, (8) land and ecosystem management, and (9) regenerative approaches in farming, forestry, fishing, and watershed management. N/A

w. FY 1990 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 for countries within the same region as originally obligated, and have the House and Senate Appropriations Committees been properly notified? N/A

2. Development Assistance Project Criteria (Loans Only) N/A

a. FAA Sec. 122(b). Information and conclusion on capacity of the country to repay the loan at a reasonable rate of interest.

b. FAA Sec. 620(d). If assistance is for any productive enterprise which will compete with U.S. enterprises, is there an agreement by the recipient country to prevent export to the U.S. of more than 20 percent of the enterprise's annual production during the life of the loan, or has the requirement to enter into such an agreement been waived by the President because of a national security interest?

c. 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?

3. Economic Surport Fund Project Criteria N/A

a. FAA Sec. 531(a). Will this assistance promote economic and political stability? To the maximum extent feasible, is this assistance consistent with the policy directions, purposes, and programs of Part I of the FAA?

b. FAA Sec. 531(e). Will this assistance be used for military or paramilitary purposes?

c. FAA Sec. 609. If commodities are to be granted so that sale proceeds will accrue to the recipient country, have Special Account (counterpart) arrangements been made?

5C(3) - STANDARD ITEM CHECKLIST

Listed below are the statutory items which normally will be covered routinely in those provisions of an assistance agreement dealing with its implementation, or covered in the agreement by imposing limits on certain uses of funds.

These items are arranged under the general headings of (A) Procurement, (B) Construction, and (C) Other Restrictions.

A. PROCUREMENT

1. FAA Sec. 602(a). Are there arrangements to permit U.S. small business to participate equitably in the furnishing of commodities and services financed? (yes)

2. FAA Sec. 604(a). Will all procurement be from the U.S. except as otherwise determined by the President or determined under delegation from him? (yes)

3. FAA Sec. 604(d). If the cooperating country discriminates against marine insurance companies authorized to do business in the U.S., will commodities be insured in the United States against marine risk with such a company? (yes)

4. 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)

5. FAA Sec. 604(g). Will construction or engineering services be procured from firms of advanced developing countries which are otherwise eligible under Code 941 and which have attained a competitive capability in international markets in one of these areas? (Exception for those 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.) (no)

6. FAA Sec. 603. Is the shipping excluded from compliance with the requirement in section 901(b) of the Merchant Marine Act of 1936, as amended, that at least 50 percent of the gross tonnage of commodities (computed separately for dry bulk carriers, dry cargo liners, and tankers) financed shall be transported on privately owned U.S. flag commercial vessels to the extent such vessels are available at fair and reasonable rates? (no)

7. FAA Sec. 621(a). If technical assistance is financed, will such assistance be furnished by private enterprise on a contract basis to the fullest extent practicable? Will the facilities and resources of other Federal agencies be utilized, when they are particularly suitable, not competitive with private enterprise, and made available without undue interference with domestic programs? (yes)
(yes-possibly CDC)

8. International Air Transportation Fair Competitive Practices Act, 1974. If air transportation of persons or property is financed on grant basis, will U.S. carriers be used to the extent such service is available? (yes)

9. FY 1990 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)

10. FY 1990 Appropriations Act Sec. 524. If assistance is for consulting service through procurement contract pursuant to 5 U.S.C. 3109, are contract expenditures a matter of public record and available for public inspection (unless otherwise provided by law or Executive order)?	(yes)
11. Trade Act Sec. 5164 (as interpreted by conference report), amending Metric Conversion Act of 1975 Sec. 2. Does the project 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, subassemblies, and semi-fabricated materials to be specified in metric units when economically available and technically adequate?	(In some cases)
12. FAA Secs. 612(b), 636(h); FY 1990 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.	(Local currency generated under ESF will be utilized to meet some project costs
13. 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)
14. FAA Sec. 601(e). Will the assistance utilize competitive selection procedures for the awarding of contracts, except where applicable procurement rules allow otherwise?	(yes)

B. CONSTRUCTION

1. FAA Sec. 601(d). If capital (e.g., construction) project, will U.S. engineering and professional services be used? (N/A)

2. FAA Sec. 611(c). If contracts for construction are to be financed, will they be let on a competitive basis to maximum extent practicable? (N/A)

3. FAA Sec. 620(k). If for construction of productive enterprise, will aggregate value of assistance to be furnished by the U.S. not exceed $100 million (except for productive enterprises in Egypt that were described in the CP), or does assistance have the express approval of Congress? (N/A)

C. OTHER RESTRICTIONS

1. FAA Sec. 122(b). If development loan repayable in dollars, is interest rate at least 2 percent per annum during a grace period which is not to exceed ten years, and at least 3 percent per annum thereafter? (N/A)

2. FAA Sec. 301(d). If fund is established solely by U.S. contributions and administered by an international organization, does Comptroller General have audit rights? (N/A)

3. FAA Sec. 620(h). Do arrangements exist to insure that United States foreign aid is not used in a manner which, contrary to the best interests of the United States, promotes or assists the foreign aid projects or activities of the Communist-bloc countries? (yes)

4. Will arrangements preclude use of financing:

a. FAA Sec. 104(f); FY 1990 Appropriations Act under heading "Population, DA," and Secs. 525, 535. (1) To pay for performance of abortions as a method of family planning or to motivate or coerce persons to practice abortions; (2) to pay for performance of involuntary sterilization as method of family planning, or to coerce or provide financial incentive to any person to undergo sterilization; (3) to pay for any biomedical research which relates, in whole or part, to methods or the performance of abortions or involuntary sterilizations as a means of family planning; or (4) to lobby for abortion? (yes)

b. FAA Sec. 483. To make reimbursements, in the form of cash payments, to persons whose illicit drug crops are eradicated? (yes)

c. FAA Sec. 620(g). To compensate owners for expropriated or nationalized property, except to compensate foreign nationals in accordance with a land reform program certified by the President? (yes)

d. FAA Sec. 660. To provide training, advice, or any financial support for police, prisons, or other law enforcement forces, except for narcotics programs? (yes)

e. FAA Sec. 662. For CIA activities? (yes)

f. FAA Sec. 636(i). For purchase, sale, long-term lease, exchange or guaranty of the sale of motor vehicles manufactured outside U.S., unless a waiver is obtained? (yes)

g. FY 1990 Appropriations Act Sec. 503. To pay pensions, annuities, retirement pay, or adjusted service compensation for prior or current military personnel? (yes)

h. FY 1990 Appropriations Act Sec. 505. To pay U.N. assessments, arrearages or dues? (yes)

i. FY 1990 Appropriations Act Sec. 506. To carry out provisions of FAA section 209(d) (transfer of FAA funds to multilateral organizations for lending)? (yes)

j. FY 1990 Appropriations Act Sec. 510. To finance the export of nuclear equipment, fuel, or technology? (yes)

k. FY 1990 Appropriations Act Sec. 511. For the purpose of aiding the efforts of the government of such country to repress the legitimate rights of the population of such country contrary to the Universal Declaration of Human Rights? (yes)

l. FY 1990 Appropriations Act Sec. 516; State Authorization Sec. 109. To 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? (yes)

5. FY 1990 Appropriations Act Sec. 574. 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)

6. FY 1990 Appropriations Act Sec. 582. 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)

ANNEX D

Presidencia de la República
MINISTERIO DE PLANEAMIENTO
Y COORDINACION
BOLIVIA

SUPSO 099/90 3258
La Paz. 7 JUN. 1990

Señor
G. Reginald van Raalte
DIRECTOR
USAID/BOLIVIA
Presente

De mi consideración:

Me es grato dirigirme a usted para ratificarle oficialmente el interés de mi gobierno en que se apruebe el Proyecto de Salud Reproductiva que la División de Salud y Recursos Humanos de USAID/Bolivia está negociando con instituciones de los sectores público y privado, entre las cuales figura el Consejo Nacional de Población de este Despacho.

Como es de su conocimiento, el Proyecto tendrá una duración de 5 años y contemplaría una contribución de USAID/B de aproximadamente $ 1.1 millones para el sector público.

Este esfuerzo se halla enmarcado dentro del Plan Nacional de Salud Materna y Desarrollo/Supervivencia Infantil que se aprobó como política directriz en el sector salud para Bolivia durante esta administración.

Cabe recalcar que la participación de la Secretaría Técnica del Consejo Nacional de Población (CONAPO), en el mencionado Proyecto se circunscribirá a sus específicas funciones de normar, dirigir y coordinar las políticas de población.

En el entendido de que la participación oportuna de las reparticiones estatales involucradas en el Proyecto permitirá un intercambio de experiencias util, esperamos que en el proceso de elaboración se considere la presencia de representantes de este Ministerio.

Con este motivo, saludo a usted atentamente

Arq. M. A. Jorge Urquidi Barrau
Subsecretario de Inversiones Públicas
y Cooperación Internacional

ANNEX E

ECONOMIC ANALYSIS

Macroeconomic indicators in Bolivia, such as those on inflation and real economic growth, show improvement when compared with those of the mid 1980's. However, future rapid economic progress is not anticipated.

1. The Economic Crisis

The average annual growth rate in GDP of 4.5% registered over the 15-year period 1965-1980 turned negative throughout the 1982-85 period. Real GDP declined by 10% and real per capita GDP by 20%, between 1980 and 1985. Both internal and external factors contributed to the economic downturn. The hyperinflation, excess government spending combined with declining revenues, high interest rates, overevaluation of the currency and price controls, were the major internal factors, while low export prices for tin, a fall in external disbursements and a rise in international interest rates are examples of the external ones. The hyperinflation reached an annualized rate of 45,000% in August 1985 before it was brought under control with a drastic stabilization program implemented in August of 1985. A combination of restrictive monetary and fiscal policies have resulted in the drastic reduction of inflation -only 15.2% in 1989- and relative exchange rate stability. In spite of the success of the stabilization program, Bolivia still faces serious balance of payments disequilibrium and structural problems in Central Government finances, both significantly aggravated by delays by Argentina on payments for Bolivia's gas exports.

The economic crisis had negative effects on GOB expenditures for health services and on the health status of the population. The crisis might have reduced further the GOB's interest in addressing long-term problems - such as family planning - as economic stabilization and reactivation commanded priority attention.

During 1989, the Bolivian economy grew, but at a lower rate than expected. The GOB had set a goal of 3.5% of economic growth for 1989. Official figures show only a 2.4% growth, with negative per capita growth. The main factors contributing to the growth of the economy were: the recovery of the mining sector, due to increases in the prices of tin, gold, and other mining products; the improved performance of the manufacturing sector; and the housing and other building activity which was stimulated by the Fondo Social de Emergencia and Gobiernos Comunales activities. However, the growth of the private sector was limited by high interest rates, depressed aggregate demand and limited credit availability.

2. Population Growth Rate

Social problems such as unemployment, falling family income and severe poverty continue to affect Bolivia. Bolivia is one of the few countries in Latin America showing a large increase in the population growth

rate as a result of a decline in the death rate and a continuing high birth rate. The annual average population growth rate of 2.7% for the period 1980-87, according to the World Bank's 1989 World Development Report, represents almost a 13% increase over that for 1965-73. Bolivia's population growth rate may be expected to continue to rise if no specific actions are taken to encourage the expansion of reproductive health services. Certainly, the population growth rate of 2.7% per year is affecting the economic situation of Bolivia and having a negative impact on the state of health services, education and housing of the population. Bolivia has a fertility rate 50% greater than that of its neighbors, and an infant mortality rate of 102/1000 according to the 1989 DHS. Only 12% of women use modern contraceptive techniques. Furthermore, about 48% of all gynecologycal beds in the IBSS hospitals are occupied by women suffering from complications from abortions.

Other economic reasons for reducing births were mentioned in the PID; and as they continue to be very valid, those reasons are repeated here:

Impact on GDP growth

We have noted that the country's real GDP actually declined each year over the period 1982-86, and that the real per capita GDP has declined by some 26% between 1981 and 1987. Even if we assume that the real GDP can grow by 3% to 4% annually over the next 5 to 10 years, this would mean, with a 2.7% annual population growth rate, an increase in per capita GDP in the range of only 0.3% to 1.3% annually. This allows no improvement in the living standard for the great majority of Bolivia's population.

Impact of Employment

The labor force in 1988 is estimated approximately at 2,278,000. It is growing at an annual rate of at least 3%; 68,000 new jobs must be created annually to absorb the growth of the labor force. Over a five-year period some 350,000 jobs (even without compounding) will have to be created. The open unemployment rate is already as high as 20%, with unemployment plus underemployment estimated at over 50%. If the population continues to grow at 2.7% annually, the unemployment and underemployment rate is much more likely to increase than to diminish.

Impact on Health, Education and Housing Services

The government has repeatedly acknowledged that its outlays on the social sector are woefully inadequate, and that standards in this area have fallen significantly for the majority of the population since 1980. The proportion of the budget that the government has been able to devote to the social sector has declined significantly in recent years. Between 1980 and 1987, the amount in the current

budget assigned to the Ministries of education, health, and housing declined from about $366 million to only $211 million, a cutback of 42% in nominal terms. The reduction in real terms would be substantially larger. With a 2.7% annual population growth rate, the government would be hard put even to maintain the current standard of service, let alone meet the need for improvement.

At present, the Ministry of Health and Social Security is spending substantial sums on the medical treatment of patients suffering from complications of abortions. These expenditures should decline significantly if reproductive health services become readily available to those who desire them.

Impact on Social Investment

The GOB's argument that what is needed is a shift in the population from the overpopulated Altiplano to the Beni, the Chaco, and the Santa Cruz areas does not constitute a solution, because massive population shifts call for substantial investments in social and physical infrastructure, agricultural credit, research, and extension services, etc. This would require substantial resources that the public sector does not have, and is not likely to be able to obtain in the foreseeable future.

3. Benefit Cost Analysis

The project team recommended against undertaking a benefit-cost analysis for this project as it was strongly felt that an economic rationale for the project would weaken the case for it as far as the GOB is concerned: economic arguments are rejected by those opposed to family planning on religious or political grounds. The Project Team argued that the GOB agreed that the Project was fully justified on health grounds alone, particularly in view of the large number of women suffering from serious health impairments as a result of illegal abortions.

Nevertheless, the Social Security Service (IBSS) is currently undertaking a benefit-cost analysis from the viewpoint of that service delivery system alone, with benefits consisting of the savings that could be expected if hospital admissions arising from abortions could be avoided. These savings can be expected to be considerable as some 48% of all Ob Gyn hospital beds in the IBSS are filled with cases resulting from abortion complications. The results of the study are not yet available, but indications are that the B/C ratio will be strongly positive.

This project is justified by virtue of the many health benefits that would accrue to both mothers and children as a result of family planning and better child spacing. The major benefit will be a reduction in the abortion rate and of the complications resulting from them.

4. Cost Effectiveness

The major implementors of this project will be the AID/W Cooperating Agencies, Bolivian private sector reproductive health and training organizations, the Bolivian Social Security Institution, and the Ministry of Health (in areas where the Pronima III project is not operating). We believe this to be the only feasible alternative, given current political constraints.

In the absence of political constraints, an alternative would be to work throughout the MOH and IBSS, since they have the largest delivery systems. This would have two main disadvantages. First, the program would be much more vulnerable to changes in government policy and practices. Second, it would leave the consumer with a limited range of choices for obtaining services and supplies for reproductive health matters. As this is the first ever bilateral reproductive health project of USAID/Bolivia, there is no experience to guide selection of the most cost-effective service delivery locally. Therefore, cost-effectiveness analysis will be an important part of evaluation of services. It may be found that costs per active user of family planning methods through the PVOs are lower than operating through the MOH and IBSS, because they run smaller, more easily supervised and more decentralized organizations. At the same time, their geographic coverage is quite limited, and extending their service delivery systems could be quite costly.

At this time, given the persistance of strong opposition to family planning by influential segments in Bolivia society, the wisest course appears to be to implement the project with this mixed system. At a later time, when there is some cost effectiveness data to analize the situation, a determination can be made whether, in Bolivia, this or some other strategy for service delivery is the most cost-effective.

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ANNEX F

SOCIAL SOUNDNESS ANALYSIS

The social feasibility of this Project depends on being able to educate the target populations about the health benefits of reproductive health. Several factors have been put forward to explain the low acceptance of family planning in Bolivia. Generally, they are based on macho attitudes, poor health conditions and ignorance. In order to overcome these barriers, the Project will have to break down traditional beliefs and promote attitudinal changes through working with the existing community structures and providing sex education, reproductive health promotion and services. Providers will have to address both language and cultural barriers when working in the communities. Although the Project targets mainly the urban population, many persons in that population still adhere to traditional attitudes and behavior.

Although Bolivia has three major ethnic divisions (the Aymara in La Paz and the Altiplano, the Quechua in Cochabamba, and the mestizo people of Santa Cruz), certain cross cultural similarities exist. Sex roles of men and women are fairly similar throughout the country as is the role of the traditional medical providers. Although community relations vary, certain activities exist within each of the communities that could be used to promote reproductive health services.

Sex roles. Within each of the Bolivian societies macho attitudes are pervasive. Men make the political and economic decisions, while women are expected to care for the house and children and generate income for the family. Women are generally the stable factor in the household, while men are frequently absent on business or pleasure. In designing a reproductive health IEC and service delivery strategy, it will be important to address macho attitudes and attempt to break them down. By educating women about reproductive health they may be willing to take a more active role in caring for themselves. Also, since women are a stable force in the household, a CBD strategy may be an effective way of educating them and providing them with reproductive health methods.

Traditional health practices. Among the Quechua and Aymara, traditional healers are an important part of the community. Since among these people traditional providers are considered experts, it is important that they become aware of the health benefits of family planning and other reproductive health care services. With training, they could serve as a valuable link between providers and communities. They could be trained to distribute barrier methods and refer women to the modern health sector for other methods especially in cases of potential high risk pregnancies. Health practices among the indigenous groups can be modified through reproductive health education. IEC materials can stress that through longer birth intervals, and avoiding births among women of high parity or too young or too old an age, infant mortality can be reduced.

Community relations. In each of the communities, structures exist that can facilitate reproductive health promotion and services. Among the Aymara and Quechua, unions are strong political entities. In some instances, the unions have offered space for the provision of reproductive health services. Mothers' clubs tend to be active throughout the country, and they provide an opportunity to educate women about reproductive health. Community gathering places such as markets and fiestas can also be used. In promoting family planning as a reproductive health activity, it may also be possible to work in conjunction with other public health programs.

Although the cultures found in Bolivia are very different, several similarities exist. In addressing these underlying social structures and working through them, it will be possible to provide reproductive health education and services. The important factor in designing these activities, though, is working with the existing structure and insuring that the messages that are presented are understandable and culturally acceptable.

Women in Development

Family planning plays an integral part in raising the status of women. In this Project, reproductive health serves as a tool for promoting better health for women and children. Improving women's health status will increase their economic opportunities. At the same time, reproductive health provides women with a means of controlling their fertility and reducing their dependency on abortion. Raising the level of consciousness may prompt women to challenge the traditional, macho attitudes that tend to influence Bolivian thought.

The IEC activities included in the Project will provide the public with information on the health benefits of reproductive health. Educational materials about reproductive health will be available in clinics and will allow women to make an informed decision about contraception. Talks given to mothers' clubs and similar organizations will provide women with knowledge about reproductive health and sex education. During the second and later years of the Project, mass media campaigns will be undertaken. The campaigns will emphasize the health benefits of reproductive health and promote the status of women.

Several training opportunities will also be made available to women through the Project. Volunteer promoters are one of the primary vehicles for service delivery. Promoters generally are women from the community who are trained to provide information about reproductive health and distribute methods. Within the family planing organizations, training will be provided for medical and paramedical staff, administrators and educators. Since a large proportion of those working with reproductive health organizations are women, many opportunities will exist for women to improve their skills level.

It is difficult to discuss reproductive health without considering how it affects the status of women. This project addresses improving the status of women by providing them with education, training, and the opportunity to decide freely as to the number and spacing of children they will have.

ANNEX G

INSTITUTIONAL/TECHNICAL ANALYSES

1. MINISTRY OF HEALTH

An analysis of the structure and needs of the MOH was conducted in conjunction with the preparation of the Community and Child Health Project in 1988, and is copied here. This Institutional analysis has been divided into the following components: Administrative Structure, Physical Resources, Personnel Management and Education.

Administrative Structure

The Health System in Bolivia is comprised of various institutions grouped in two sectors:

Public: The Ministry of Social Prevision and Public Health (MOH); Social Security; and others that also develop health actions such as: Junta Nacional de Solidaridad (National Committee of Social Solidarity and Development); Accion Civica de la FFAA (Armed Forces Civic Action), and Desarrollo de la Comunidad (Community Development).

Private: Private for-profit institutions (clinics and private consultant professionals) and non-profit institutions such as PVOs.

The distribution of responsibility for attention to patients has been:

Public Sector:	MPSSP (MOH)	68%
	Social Security	25%
	Other Institutions	5%
Private:	PVOs and others	2%

It is important to note that real coverage of the MOH is approximately 40%, and in the rural area it does not surpass 20%. The MOH is structured as follows:

Central Level: Minister's Office, Sub-Secretary of Public Health, Sub-Secretary of Social Prevision, General Health Direction, other technical offices, and an administrative support office.

Regional Level. These are 11 Sanitary Units in the different departments: La Paz, Cochabamba, Santa Cruz, Potosi, Chuquisaca, Oruro, Tarija, Beni, Riberalta, Tupiza, and Pando. Each sanitary unit is headed by a Director, who represents the MOH. Each sanitary unit is comprised of districts, further divided into areas and sectors.

Local Level. This is the level at which health services are offered to the community. In descending order of levels of care, they are: Institutes and Centers for Research, Specialty Hospitals, General Hospitals, Health Center-Hospitals, Health Centers, Medical Posts, and Sanitary Posts.

MOH Functioning

Policy. The Minister's Office and the Sub-Secretaries are responsible for the definition of policy and strategy that serve as scopes of reference for the development of health programs.

Technical. Within those parameters, the national level Directorates elaborate the technical content of the interventions to be executed by each one of the divisions in the sanitary units.

Administration:

Personnel. There is a statute for the hiring of employees that is not utilized in all cases. Once the employee is nominated for position, the Minister's signature is required. This mechanism is followed for all MOH employees and for all offices under the MOH.

Budget. The resources for payment of salaries come from the National Treasury and they are sent to each Sanitary Unit. Most of the resources for development of projects and programs derive from foreign aid.

The following summarizes key characteristics of the MOH:

- The MOH and the Sanitary Units have inadequate organization.
- There are many vertical programs with a complete lack of coordination.
- Administrative processes are very complicated in relation to social and structural characteristics and constitute a restraining factor.
- The information system shows a series of deficiencies causing generated data to be incomplete, inopportune, and generally not reliable.
- Although many employees work hard, the lack of clearly defined objectives in their work does not allow them to accomplish analytical activities.
- Most MOH activities are focused on curative actions and not on preventive measures.
- Administrative proceedings are very cumbersome. As an example, an auxiliary nurse spends more than two days each month in the process of being paid, which requires 13 to 19 signatures.

Physical Resources

The MOH has a network of services installed all over the country. It has investigation centers like CENETROP, Centro Nacional de Enfermedades Tropicales (National Center of Tropical Diseases) and the IBBA, Instituto Boliviano de Biologia de Altura (National Institute of Altitude Biology).

The MOH has 22 Specialized Hospitals, 12 General Hospitals, 151 Centers of Health-Hospitals, 17 Health Centers, 83 Peripherial Medical Posts, 126 Medical Posts, and 864 Sanitary Posts. All Sanitary Posts are in the rural areas, as well as the medical posts and the Centers of Health-Hospitals. Only two specialized hospitals are in rural areas: Jorochito Hospital in Santa Cruz, and Candua in Chuquisaca.

The MOH has 7,500 hospital beds. Only 37% of these are in the rural areas. Close to 95% of all establishments in the rural area belong to the MOH.

The health services have the following characteristics:

- The percentage of occupied hospital beds is barely 40-50%.
- Each hospital bed renders, yearly, 17 hospital discharges.
- Much of the equipment cannot be utilized because the health workers are insufficiently trained its use.
- Donations of equipment received from different agencies do not permit a proper maintenance process, since they are often of diverse brands and types.
- The output (efficiency) per hour/physician is very low. In some hospitals the figure does not reach five patients per day.

Personnel

In 1987 the MOH had 11,921 employees. Of them, Doctors constitute 15%, Dentists 2%, Professional Nurses 8%, Auxiliary Nurses 23%, other professionals 11%, Administrative 18%, and Service Personnel 23%. Of the 1957 physicians, only 24% work in the rural areas. Most personnel are auxiliary nurses (2,752), and 49% of them are working in the rural area. Of all MOH employees (11,921), 2,889, or 24% are working in rural areas. The lack of nursing personnel is evident, since for every ten physicians there are only five graduated nurses. For every eight auxiliary nurses there is only one graduated nurse. Many employees are inefficient and not motivated to perform effective actions for public health. Frequently, authorities of different levels hire employees for reasons of politics or personal friendship, without considering professional capacity or technical MOH requirements. Many personnel changes occur, in part because salaries are low and capable employees prefer to leave. This atmosphere fosters a lack of initiative and responsible dedication to work, and creates instability.

Education

Bolivia has three medical schools: La Paz, Cochabamba, and Sucre; and four faculties of dentistry: La Paz, Cochabamba, Sucre, and Tarija. Some of the faculties of medicine also have Nursing Schools. Of approximately 200 to 250 professionals graduated each year, only 50 are professional nurses. Medical studies last six years with one year of hospital

internship. Four years of study are needed to attain bachelor's in nursing. Physicians, dentists and nurses must fulfill one year of compulsory rural service (año de provincia), although many times they choose to pay a fine rather than to fulfill this obligation.

Medical schools are in most cases oriented to the creation of scientific physicians, surgeons, and biologists, whose preparation is not appropriate for the reality of medical practice in rural areas. Medical schools do not have administration and health promotion programs. Graduates, therefore, are inadequately trained to fulfill these functions.

1. BOLIVIAN INSTITUTE OF SOCIAL SECURITY/ CAJA NACIONAL DE SALUD

Administrative structure

The Ministry of Public Health and Social Prevision in Bolivia is composed of two branches: social security and public health services. The social security branch under the Undersecretariat for Social Prevision has the IBSS as its technical, normative and supervisory body. All social security schemes in the country fall under IBSS, among which the Caja Nacional de Salud (CNS) which is the entity in charge of the health services delivery for the insured population. The pension funds are separated from service delivery funds.

The Bolivian Institute of Social Security (IBSS) provides health coverage for those salaried employees who are associated with it. The affiliated employees are almost entirely urban workers. The social security system covers 1,009,571 (1987) employees and their families or about 16 percent of the Bolivian population. There are no fees for the health services provided. The services are financed through obligatory contributions from the employees (3.5% of their salary) and from their employers (8% of salaries paid). In 1988 the budget for the health services provided by the IBSS was the equivalent of US$ 43 million (80% for the CNS). 32% (or 466,000)of the persons receiving health services are women. Of that number some 24% (or 112,000) are of fertile age (15 to 49 years). By far the leading cause of hospitalization of this group is complications from abortion performed outside the IBSS system.

The CNS is however an autonomous body with an independent budget coming from labor, employers and State contributions. The GOB contributes both as state and as an employer. Its administration is also autonomous. It consists of a Directorate composed of labour, employers and state representatives, as an advisory body, under which is the Presidency or Executive Director. There are four Managers: the general manager, one for health services, one for administration, one for general services. There are also nine regional administrators.

Physical Resources

The CNS has hospitals in all the major cities of Bolivia, 45 centers or "consultorios" for outpatient services in the country are provided through those outlets, not through private physicians. Of its 27 hospitals, 5 can be considered for tertiary care, in La Paz, Santa Cruz, Cochabamba, Oruro and Sucre. Wherever there is no infrastructure of their own, they rent facilities from the MOH on the basis of hospital beds. These hospitals have 2,201 beds in total, with an occupancy level of 53.7%. The outpatient reached 1,412,558 in 1987.

The largest hospital in the system is the Hospital Obrero in La Paz. It provides a full range of services including obstetrics and gynecology. Those latter services are provided by a staff of 27 including five part-time doctors, eight full time residents and thirteen nurses. The group provides both inpatient treatment and outpatient services three afternoons a week. The outpatient services reach approximately 70 women per week. Of the approximately 1,000 women hospitalized, some 48% suffer from complications from abortions.

In response to the high rate of medical complications from abortions the Hospital Obrero began to offer family planning services in January 1988. As part of the program the hospital offers temporary contraceptive services such as pills, spermicidal vaginal tablets, and IUDs. (Condoms are not in demand, and the sterilization of women will be performed only for a valid medical reason). The pills and IUDs are provided by the Ministry of Health free of charge (it receives them as a grant from AID). Although the services are provided in support of a program to reduce the rate of abortions, and is aimed at women at high risk of complications from pregnancies, any woman seeking contraceptive services will be given them. However, currently there are only 390 women receiving contraceptive services under the guidance of the hospital.

The human resources, as of 1988, were 5,698 in total, of which 1,122 are regional administrative staff, 1,141 physicians, 1740 nurses and nutritionists, 226 laboratory technicians, 137 dentists, 180 X-ray technicians, 993 maintenance and service personnel, and 159 are administrative staff at the health centers. The family physicians, who are to be in charge of the outpatient reproductive health services delivery total 187.

Program Proposal

The staff of the Hospital Obrero which works in obstetrics and gynecology have prepared a proposal for undertaking a system-wide program in support of maternal health. The proposal was approved by the Board of IBSS in October 1988. the overall purposes of the program are the following:

- to establish a clear basis for measuring maternal and child morbidity and mortality rates;
- to decrease those rates by 30% within three years;

- to introduce the concept and focus of risk into all aspects of medical attention;
- to create a unit for social communication and education to reach 100% of the insured population;
- to develop a system of organizing and utilizing patient information, and
- to establish system-wide medical norms for treatment.

Impediments Facing the IBSS and the Proposed Program

According to the staff of the Hospital Obrero the most important impediment to the execution of the program is the need to provide training to the staff of the system about the purpose and the implementation of the components of the program and information to the system's insured population concerning the program components and the steps which they should take in order to take advantage of the services of the program. The proposal includes measures to address these impediments.

Given the method of financing of the CNS system, the existence of its infrastructure throughout the country, the relatively low marginal cost to the system of increasing the coverage of the maternal health program and the probable savings in costs from less hospitalizations among the insured population, it is likely that the program can achieve financial self-sustainability relatively quickly.

3. CONAPO

CONAPO is the National Population Council (Consejo Nacional de Población). Established by government decree in 1984, it is located within the Ministry of Planning. CONAPO has the responsibility for coordinating, promoting and defining actions associated with population issues in coordination with the GOB's overall planning efforts. It consists of a council of representatives, including those from the Ministries of Health, Interior, Employment, Education, Agriculture, Housing, and Defense as well as representatives from the National Board of Social Welfare and Instituto Nacional de Estadisticas (INE). The council is presided over by the Minister of Planning. However, the council of representatives has never met.

The work of CONAPO is carried out by an Executive Secretariat which consists of five units (only four of which are currently operative): research, communication, training, documentation and women (the last currently is not staffed). The secretariat of CONAPO currently operates on a limited budget, with a limited number of staff members responsible for a wide range of activities. Financed primarily by external funding sources, its activities to date seem to be determined more by the interest of funding agencies and the resources they can make available according to their own program needs rather than according to any coordinated scope of work defined by CONAPO itself.

CONAPO's primary strength is its dedicated and hardworking staff. Despite the lack of support CONAPO has received from the GOB, the staff has carried out an impressive amount of work. It has produced a variety of research studies on population related issues. It maintains a documentation center of bibliographic material, and handles about five requests a day for population information from both the public and private sector. It has conducted two training programs, each a month long, for regional planners (one in Santa Cruz, one in Potosi) and several seminars to present research findings and it has produced a wide array of materials on population issues. Its budget for 1986 was $137,000; for 1987 it was $167,000; for 1988 it was $163,000; and for 1989 it is $239,000. Except for 1988, most of CONAPO's funding has come from AID through projects implemented by the Research Triangle Institute (RTI) and the Pathfinder Fund. In 1988 the Canadian government (IDRC) provided 86% of CONAPO's funding. Other sources of funds over the years have included UNICEF, UNESCO, UNFPA, and the PL-480 Title III Secretariat.

CONAPO has been referred to as an "orphan" within the Ministry of Planning since it has little political influence and limited input into any of the Ministry's or GOB's activities, and since it has received little financial support from the Ministry of Planning. CONAPO's political weakness stems from a lack of interest in population issues within the GOB, and it also is the result of its constant financial instability. As a result of this instability four of CONAPO's staff who had received advanced training in demography and population and development issues left for more high-paying and stable positions. There is a need for more staff with skills in computer programming and in data processing, and staff members need long-term training in population and development issues and incentives to stay at CONAPO to use their acquired skills. CONAPO needs technical assistance to bridge more effectively the gap from producing information to ensuring the effective dissemination of this information to the appropriate audiences. Much of the material produced by CONAPO has been viewed as too academic to promote an effective dialogue on population issues.

Current Program

The scope of CONAPO's current program includes the design and proposal of alternative population policies, the dissemination of population information, training in population and development issues, research and the maintenance of a documentation center. Its program for 1989 consists of the following activities: development of a model illustrating the impact of population growth on the health sector; projection of population and socioeconomic trends by ecological region; presentation of results (through publications and seminars) of a study on women, reproduction and employment; development of a study on the sociocultural aspects of fertility and mortality; holding a training program in population and development for regional planners in Santa Cruz; preparation of material on responsible parenthood and sex education; automation of its Documentation Center; development of a model for looking at the impact of reproductive health on

social security funding; preparation of indicators to be used in the analysis of reproductive risk and child survival; development of a strategy for information, education and communication in population; and the implementation of a study on nutrition and prenatal care of pregnant women.

Each of CONAPO's activities is being supported by an external donor. CONAPO's support from external funds total $238,727 for 1989. This includes $35,000 from Pathfinder, $66,000 from IDRC; $5,000 from USAID/B; $19,000 from RTI; $18,000 from John Short; and $95,000 from the USAID/PL-480 Title III Secretariat. While all of these activities are relevant to CONAPO's functions and objectives, the organization does not appear to have a cohesive strategy or timetable for achieving either a population dialogue or policy nor for defining what information should be used, how, when and with whom.

Current Operation of the Organization

There are currently 13 staff members in the executive secretariat of CONAPO. They represent a range of specialties including economics, social psychology, sociology and library science. Several have received some specialized training in population and development issues through seminars and graduate studies supported by donor organizations.

Only five of the staff receive salaries from the GOB while eight staff members receive salaries from external sources, of which three receive very low or no salaries. The staff positions which are needed are demographer programmer, a demographer/economist, several research assistants and an administrator.

Funds received from external sources are processed through the national banking system. All administrative processes are subject to periodic internal audits by the MOP. A financial report is submitted on each activity as well to the external funding agency according to the terms of agreement for the activity. The multiple administrative requirements associated with both the MOP and the various external funding sources are very time-consuming, and currently must be carried out by the technical staff. Thus it would be advisable to add a staff position to handle these administrative matters. Initially the administrative processes would be streamlined by giving CONAPO more autonomy in managing its financial resources.

The MOP has reviewed its overall structure. The restructuring includes the creation of an Undersecretary for Social Issues. CONAPO has been placed under the authority of this position (previously CONAPO reported to the Undersecretary for Economic Affairs). It is planned to set up CONAPO as an autonomous unit to address social issues. This status would be similar to Unidad de Análisis de Políticas Económicas (UDAPE) which is totally funded by funds from USAID; is an autonomous "think-tank" which provides the GOB, - and principally the MOP - with information for making economic policy

decisions. If the proposed restructuring is approved and implemented, CONAPO would receive the autonomy to manage the administrative and financial arrangements that it now seeks.

The proposed restructuring would give CONAPO a better opportunity to carry out its mandate, and the current Minister of Planning is committed to making better use of CONAPO's expertise and resources than has been the case in the past. However, the restructuring would not mean that CONAPO would be financially self-sufficient at any time in the near future. Indeed, it would continue to be overwhelmingly dependent on external assistance.

Plans for the Future

The only on-going assistance for CONAPO which is planned to extend into the future is that from Pathfinder (private funds), IDRC (Canadá) and RTI under its RAPID III project. The support would continue until 1992. It consists of the following: development of a child survival model, a health sector model, and a reproductive health cost-benefit model; estimation and projection of the number of women at high reproductive risk; evaluation and quantification of the MOH's targets in reducing reproductive risk with an estimation of the resources needed to meet them; analysis of population redistribution issues; and provision of technical assistance to the regional development corporation of Santa Cruz for producing models on reproductive health, health, education and migration impact.

An important need not included in the above program is the preparation of a population and socio-economic database. That activity primarily would consist of gaining access to major sources of population, health and socioeconomic data. The primary source of population data is INE which is to receive World Bank funding for developing a health database with the MOH. This database should contain all of the survey data that CONAPO will need for its analyses as well. The database to be developed under the AID Child Survival project will be integrated into CONAPO's database as well. Thus what CONAPO needs is support for processing these data and putting them in a format appropriate for the analyses and modeling which CONAPO is to undertake and for adding new information to the database as it becomes available.

Major Problems/Needs Facing the Organization

CONAPO's major problem in the future is gaining assurance of enough resources to maintain stability in its staffing so that it can develop and implement a cohesive strategy to foster a policy dialogue that is more visible and comprehensive than has been the case up to now. Resources are needed to maintain the Documentation Center which will be shut down after May 1989 as IDRC completes its support.

It is anticipated that consistent support for the duration of the project will enable CONAPO to establish itself as a major source of information and expertise on population issues, and it to attract increasing financial support from other donors as well as from the GOB itself as the latter becomes increasingly involved in a dialogue on population issues and dependent upon CONAPO as a coordinator of this dialogue.

Centro de Documentación en Población y Desarrollo (CENDOP)

The Documentation Center for Population and Development was created in 1987 with financing from IDRC- Canada. It is part of CONAPO.

The Center currently has a collection of over 5,000 documents, 120 of which are periodicals, and "special materials" such as microfiches, radio programs and audiovisuals. The documents from Bolivia total 2,815. In addition to hard copies all these documents are entered in a computer system. CENDOP also participates in four international data base systems. These are:

- Sistema de Documentación sobre Población en América Latina (CELADE/DOCPAL), Santiago de Chile.
- Sistema de Información en Planificación para América Latina y el Caribe (INFOPLAN) de CEPAL/CLADES, Santiago de Chile.
- Centro de Información sobre Migraciones en América Latina (CIMAL), Santiago de Chile.
- Sistema de Información del Instituto Interamericano del Niño (IIN/SIC), Montevideo, Uruguay
- Red para la Infancia y la Familia en América Latina y el Caribe, San José, Costa Rica.

The Center also produces a newsletter in conjunction with other institutions that manage social and economic bibliographic information systems. The newsletter is called CEDOIN. It provides updated listings of new information acquired by the different centers.

In addition to the activities currently being implemented, the Center plans to prepare abstracts for the existing bibliographic citations that are on its database, as having abstracts will provide much more information about the bibliographic reference and make the bibliographies and literature searches more useful. At some point, if the volume of inquiries increases dramatically or the demand for bibliographies or other printed documents increases, the Center will consider charging for the costs of its production. The Center also will expand its role to include a reproductive health library open to the public. The Center already collects reproductive health research and essays. An information system will be developed to disseminate and share the articles available to reproductive health providers

and the medical community. The Center is in a better position to carry this out than other groups which have small libraries, but which do not have the capacity to develop a reference resource meeting the needs of the family planners and medical communities, students and the public.

The services offered by the Center include:

- Literature searches
- Library reference services
- Searches in international data bases
- Requests for bibliographic or statistical information from other international data bases
- Development of bibliographies
- Assistance for thesis development, and
- Microformat printing of documents

The Center has also created a human resources file which includes listings of: i) people working in the population and development field in Bolivia; ii) institutions operating in population and development; and iii) other international services working in population and development. This database includes basic information about the resources listed above, where to locate them, their specialties and availability.

To date CENDOP has produced four bibliographies:

- Migración y Colonización
- Mortalidad y Salud
- Mujer y Familia
- Fecundidad y Planificacion Familiar

A. SOMARC

Background

The objective of the Contraceptive Social Marketing (CSM) program is to develop and implement a national program targeted on urban and rural middle and lower class consumers. Communication, promotion and distribution techniques are to be used to reach rural and nonliterate populations. A secondary objective of the program is to collect data on the various aspects of the program in order to evaluate its impact. The program is being carried out with the support of the SOMARC program financed by AID/W.

The program has three main activities:

- The commercial distribution of contraceptives (CSM)
- Research on users profiles, market audits and the use of focus groups
- Social Promotion - creating a positive attitude toward reproductive health and providing information on specific family planning methods

The commercial contraceptive distribution is handled by a private Bolivian distributor of pharmaceutical products, ABENDROTH, which imports the products (some of which are donated to it by AID/W) and covers all import duties, packaging and transportation costs. It is responsible for establishing the distribution network and for placing the materials in the pharmacies. ABENDROTH is a for-profit, commercial distributor of drugs and related products. It is registered in Bolivia according to commerce and trade regulations. It has a long tradition of working in the Bolivian pharmaceutical market, being the distributor for SYNTEX which produces Norminest, Noriday and Norquest oral contraceptives among other products.

The research aspect of the program is handled directly by SOMARC which has been financing and contracting specific studies. Some of the research activities have been:

- general knowledge, attitudes, and practices surveys in 1987, and baseline pharmacy audit as an ongoing evaluation tool, pharmacy audits will be carried out every 6 months, starting in 1990 to measure changes in sales of CSM brands and other brands to determine the extent to which objectives are reached.
- focus groups for testing reactions to advertising
- Demographic and Health Survey; SOMARC financed a 1,000 respondent oversample in three districts of La Paz. Twenty questions were added to the regular questionaire , pertaining to Noriday, other brands of oral contraceptives, and awareness of the SOMARC ad campaign. Results are currently being analized.
- a survey of 75 Ob/gynecological and general practioners in La Paz, Cochabamba, and Santa Cruz regarding attitudes and practices regarding family planning

The social promotion aspect consists of the preparation and dissemination of TV spots and posters, among other materials, and product support material. Social promotion was sponsored by the Sociedad Boliviana de Ginecologia y Obstetricia (SBGO), which is a medical society registered and recognized by the GOB. This is now funded directly by the Mission.

There is no formal relation of the program with the GOB except for the legal registration of the products by ABENDROTH. SOMARC has no legal status in Bolivia.

The following paragraphs summarize the program's efforts to date and the composition of its current activities.

Objectives

The target population of the program is the approximately 506,000 women and men of fertile age (15-49) both in the rural and urban areas

of Bolivia. The products included in the program are oral contraceptives and condoms. However, the handling of condoms has been postponed because of the large quantities already available in the market both from regular and contraband sources and from governmental and reproductive health institutions.

The initial objectives were the sale of 20,000 cycles of Noriday, (standard dose) and, by the second year, to have registered and made available in the market a low dose oral contraceptive. By March 1989 62% of the 1989 goal for sales had been reached, and 13,064 cycles had been given away as well. As of March 1989, $36,565 in SOMARC funds had been spent on product sales and training materials. Through October, 1989, over 32,000 cycles of Noriday had been sold, 80% above target, with 36,000 cycles expected to be sold through December of 1989. Almost 20,000 cycles had been provided as professional samples to physicians for product promotion purposes.

Approach to IEC

A large awareness campaign was conducted in 1988-89 with SBGO in order to create a more positive attitude towards reproductive health. The main media have been TV and radio spots and posters oriented towards the reduction of abortion; the prevention of venereal diseases; the control of high risk pregnancies; and encouraging child spacing. As this is a new campaign, no results can be measured at this moment. As of March 1989, $176,796 in SOMARC funds had been spent on this activity.

Approach to Training

A training program for pharmacists has been developed, and a total of 36 training sessions have been delivered to 720 pharmacists and pharmacy workers. The training is in reproductive health with an emphasis on the use of the pill. The cost has been US $2,640 through March 1989.

Approach to Operations Research

An operations research project was started in August 1989 with PROSALUD, to determine the most feasible system for distribution of CSM products and family planning and other reproductive health information in a remote rural area north of Santa Cruz. Results from this study will guide the development of a pilot rural distribution project during 1990.

Approach to Planning and Evaluation

Because of the previously mentioned difficulties and the delayed start, no formal evaluation of the program has been carried out except for focus group evaluations of advertising and promotional materials. The evaluation plan includes planned pharmacy audits and users profiles.

Estimate of Cost Effectiveness and Prospects for Cost Recovery

In order to estimate the cost effectiveness of SOMARC, it must be kept in mind that the initial effort included significant activities to create a positive attitude towards reproductive health and as well as making Noriday generally available. Using a very simplistic approach to calculate the cost per cycle distributed does not make sense as a large part of the expenses should be considered investment in raising awareness of family planning as part of reproductive health, and making information available about family planning methods, thereby generating increased demand for all products and methods, including CSM brands. Indeed, under the limited present market of the "normal" dose contraceptives, such as Noriday, it is clear that self-sufficiency is not possible unless all promotional and product support expenses are excluded from the costs.

With more products, a larger market, and greater sales figures, the cost per cycle distributed should be lower. The increase in the number of products (as not only more oral contraceptives are included, but condoms and IUD's as well) will mean a larger volume of sales with the same sales force, and this will mean a lower cost per unit. Another factor that will affect not only cost effectiveness, but also cost recovery in the future is the fact that the new low-dose and triphasic oral contraceptives will be imported by ABENDROTH which will cover the full commercial price of the product plus all import duties, transportation, etc., making the total operation a "for profit" one. SOMARC will continue to provide promotional support for the effort, as product importation and distribution begin to pay their own way. The extent of that market-creating effort should be reconsidered in the future when data about users is made available.

Cost recovery figures should be developed, but with the limited number of cycles being distributed and the short time during which the program has been active, current figures are not meaningful. During the life of the Project cost analysis and cost recovery studies will be conducted to test the evolving financial sustainability of the system.

Problems and Needs of the SOMARC Program

The major problems/needs identified during the analysis of the SOMARC program in Bolivia are the following:

Marketing Issues: In the marketing area there are a number of problem areas and issues which must still be addressed.

- The low price of "contraband" contraceptives that come from neighboring countries reduces the commercial attractiveness of the social marketing system

- Bolivia has only a limited market for contraceptives because of its relatively small population and the currently low prevalence of contraceptive use
- Sales of Noriday (normal dose) cannot be financially self-sufficient because of its low sales price (B. 1.50) and low margin for profit in a very small market with low-priced competing products
- The limited number of contraceptive products currently being offered limits the attraction of the line to pharmacists
- Some of the donated products are going into the pharmacies in competition to the SOMARC system
- There has been a delay in achieving registration in Bolivia for Micro nor (low dose oral Contraceptive) by Abendroth

In order to meet these problems SOMARC proposes to develop a better managerial structure at the Bolivian office level, and to move the office to Santa Cruz, where it may eventually become part of PROSALUD. However, the basic solution to meet the marketing problems will have to come from:

- access to low-dose and triphasic oral contraceptives
- development of a larger contraceptives market in Bolivia
- new products that will provide better margins for pharmacists, and will provide a better income for ABENDROTH.

Management Issues

In management, improvement is needed in the collection and handling of information now that SOMARC has adopted a set of goals and objectives based on its actual experience in Bolivia and not just on theoretical assumptions. An effort should be made to develop the concepts of planning, controlling and monitoring procedures into managerial tools.

5. CENTER FOR INVESTIGATION, EDUCATION AND SERVICES (CIES)

Background

The Center for Investigation, Education and Services (CIES) is a non-profit organization founded in June 1987 with the purpose of conducting studies and projects aimed at promoting an improved standard of living for the Bolivian population, especially women, adolescents and children. Among the organization's objectives are: providing information about maternal-child health, sexuality, reproductive health, and women's rights; assisting in improving medical services related to maternal-child health and reproductive health; and performing research on educating, and modifing the sexual attitudes of the Bolivian population.

In its three years of existence CIES has established itself as one of the major providers of reproductive health services in the country. The organization has already obtained its legal status. In the past, CIES has been project based, and has hired staff according to the needs of the particular activities undertaken. It has now organized itself into departments (services, communication and education, research and administration), and has developed a three year strategic plan.

Organization

Currently CIES employs 53 people most of whom are working on specific projects. The organization has a full-time Executive Director who is involved in supervisory activities and works closely with union leaders in promoting reproductive health and health activities. Accounting and financial matters are managed by a half-time administrator who also works in the MOH. Each of the clinics has a physician, an auxiliary and educator.

The Executive Director is part of the Technical Council which is composed of Directors of four Departments. This Council meets weekly to discuss administrative issues and monitor the projects' progress. Each of the department heads coordinates activities across service projects. The Director of Medical Services is in charge of service delivery in all three projects. Each of the three projects has a coordinator and stores its commodities separately. The person who manages the commodities for each project also manages a petty cash fund.

Since the organization is still funded through projects, it is necessary to keep separate financial records. The administrator has bank accounts for each donor agency and a savings account for the revenues generated from the laboratory. This arrangement allows the administrator to know how much money is on hand for each of the projects.

A computerized management information system (MIS) provides CIES with information on the types of services provided and the reproductive health methods distributed and basic demographic information on users. Reports are completed by the auxiliaries in the clinic, indicating if the patient is new or returning. CIES is trying to modify the MIS clinic forms so that it can also include the information from the clinic in El Alto (FPIA, which funds the clinic, has different reporting requirements and provides specific forms to be used for capturing patient information.) The community based distribution (CBD) program is also included in a database. The volunteer distributors are supervised by the promotors who complete a form on new users and monitor the continuance of current users. The information is passed on to the educators who monitor referrals to the clinics from the distributors. Summary information is entered into the computer. The CBD data base requires more supervision; consequently, it is less efficient than the clinic-based system.

Current Clinics' Activities

Most of CIES' activities have been funded by Pathfinder, FPIA and the Population Council. Pathfinder's current activities include the funding of three clinics in Bolivia's three major mining areas: La Paz, Oruro, and Potosi. Additional coverage for these clinics has been obtained through the use of affiliated physicians who provide reproductive health services in the area and through a community based distribution program. FPIA funds a clinic for maternal child health and reproductive health services in El Alto. This clinic's activities also are supported by the use of affiliated physicians and CBD program. The Population Council has funded a mobile clinic for CIES which provides services once a week in the offices of four of the unions in La Paz. It also includes a CBD program.

The La Paz clinic funded by Pathfinder operated successfully during the first three-quarters of 1988. However its relocation in December resulted in a drop in the number of consultations. The Oruro clinic opened on time, and the Potosi clinic opened two months behind schedule.

Date for utilization of services (consultas) during 1989 is the following:

	LA PAZ	ORURO	POTOSI
Pediatrics	346	966	480
OB/GYN	2,204	1,785	1,570
FP	1,028	370	357
Others	68	19	153
Total	3,646	3,140	2,560

The clinic in El Alto, funded by FPIA, is functioning at capacity level. The demand for information and services in this area is very high, and few providers deliver services in this impoverished area.

During 1989 the clinics at El Alto and Viacha provided the following attentions:

Pediatrics	1,940
OB/GYN	3,256
FP	1,640
Others	1,629
Total	8,465

The CBD program at El Alto and surrounding peri-urban area obtained 2182 new users during 1989.

The "mobile" clinic sponsored under a Population Council operations research project provides clinical services once a week at the offices of the unions for factory workers, campesinos, teachers, and university students. The clinic handled 773 office visits between March and December 1988. Of these visits, 54% were for ob/gyn and 19% were for reproductive health. The clinic services have provided reproductive health methods to approximately 165 users 55% of whom use IUDs. The clinic also supports 186 CBD users who are served through union-based promoters. The promoters provide educational information to the union members and distribute barrier methods.

Overall management of the clinics is coordinated through the Director of Medical Services who periodically makes supervisory visits to the clinics. The Director of Services also coordinates activities with the MOH. Day-to-day management of the clinics is under the responsibility of the three project coordinators. These coordinators are also responsible for the educational activities and the CBD workers. Within each of the clinics there is an auxiliary nurse who manages the patient records, fees generated and MIS data.

IEC Activities

CIES has been involved in several types of IEC activities. Most of the activities revolve around promoters who work with community groups in CIES's target areas. The sessions utilize flipcharts and flannel and black boards, and are supplemented with reproductive health and health pamphlets. To date approximately 40,000 people have been reached through the informal sessions. CIES also has recently produced a reference manual to assist the promoters in their educational activities. The manual was developed from the promoter's own experiences and pretested by them. Indeed, CIES' staff appears to have a good understanding of the attitudes, words and symbols unique to the Aymara people. This has helped in the development of culturally appropriate materials.

In addition to printed materials, CIES has worked with television. During 1987 the organization received 1/2 hour per week of free air time for a period of six months. Each of the shows focused on a different topic, including reproductive health. CIES also has developed radio spots. Currently, in Oruro and Potosi it has access to free radio time on different stations.

Training Activities

CIES' training activities are directed toward promoters and physicians. CIES received training of trainers from Development Associates Inc. (DAI), and since then has developed a training manual and other materials for their promoters. Additionally, CIES is

providing training in reproductive health and maternal child health matters to the Bolivian Society of Traditional Health Providers. The organization is also involved in medical training for its affiliated physicians. The Director of Medical Services received training from Pathfinder several years ago, and has begun to instruct interested providers using CIES clinics for training. To date CIES has trained 286 promoters for community work and 23 physicians in IUD insertion.

Operations Research

CIES undertook an operations research (OR) project, evaluating the medical backup component in conjunction with a CBD program. Based on the results, the organization will determine if the once per week clinic approach is an effective way of increasing acceptance. CIES is planning a follow-up study that will provide services to several of the campesino unions. Another benefit of the OR activity is that it helped CIES to design a computer based management information system to cover all the service delivery components.

Planning and Evaluation

Planning is now a high priority for CIES. Having established a three year plan, the organization has decided upon the activities that fit into its aims. Now evaluation needs to be better incorporated into CIES' operations. It needs to develop a means of evaluating the quality of its services. Currently, it uses a monthly service statistics report as a basis to evaluate its progress, and holds meetings to evaluate the different components of its program. The CBD program is monitored through weekly meetings because this is the area that needs the most reinforcement. Monthly meetings are also held with the educators and promoters. The organization conducts semi-annual and annual internal evaluations in order to assess its progress and to evaluate its strategic plan. However, it needs to be more careful in planning the targeted number of new users since it consistently falls short of achieving its goals. MSH/FPMT sent a consultant in 1989 to help CIES prepare an strategic plan and establish a sounder organizational structure.

Financing

CIES is almost totally dependent on external funding. It receives financial assistance from Pathfinder and FPIA. It has received assistance from the Population Council and Development Associates. It appears to be using the technical assistance and financial resources fairly wisely. The donor agencies have instilled in CIES the idea that it should be moving toward self-sufficiency. With money made from service provision, the organization has opened a small laboratory in the El Alto clinic which nets a profit of $350 per month. CIES is interested in opening a large laboratory and obtaining ultrasound equipment for the La Paz clinic as ways of generating revenues for its activities.

CIES is looking for additional sources of financing. It wants to open small pharmacies in the El Alto and La Paz clinics, and is seeking funds from European organizations to do so. Pathfinder's financial support is expected to continue. FPIA's funding period with CIES has not ended; although future funding is uncertain, it is highly likely that FPIA will continue to support the El Alto clinic. Funding from the Population Council was for a research project which ended in March 1989. CIES obtained a bridge-funding until December 1989 from AID.

With a small investment the laboratory could conduct a much wider range of analyses and generate approximately US$ 4,800 per year. CIES is also interested in a laboratory for its La Paz clinic. It has discussed cooperative agreements with other clinics and reproductive health groups, and thinks that it could generate US$ $12,000 per year in revenues from the clinic. A third activity would be the installation of ultrasound equipment. Currently this service is not available to low income women through either the MOH or private clinics. By referring women from El Alto and other physicians, CIES estimates that providing ultrasound could generate about US$ 3,000 per year.

Goals and Plans for the Future

CIES has developed a three year strategic plan focusing on activities in research, education and service aimed at women, their health and their sexuality. It has developed an ambitious agenda in each of the three areas. Research interests include: male and female sex roles among the Aymara and Quechua in order to find effective ways to work in rural Andean areas; adolescent sexuality working with the Federation of Secondary Students in "Life Planning" activities; reasons for not using reproductive health methods; women's perception of their own bodies and perceptions of abortion (with the Fundación San Gabriel); and information from user records in order to develop a marketing plan regarding users and promoters. Educational activities include: five day training courses for promoters; talks with mother's clubs, health committees and traditional health providers; short papers developed to stimulate intellectual dialogue; manuals for CBD workers and promoters on maternal-child health and reproductive health; a manual for promoters on sexuality; radio campaigns; information on reproductive health and women's rights; and a manual for rural health workers. Service activities include expanding the existing clinics, and providing better counseling to prospective users.

The goals for reproductive health users in 1988 were overstated, and CIES was not able to reach them. During late 1988 and early 1989 CIES activities have become more accepted by the public. Activities in Oruro and Potosi have increased. The goals established for the La Paz/Oruro/Potosi clinics funded by Pathfinder for 1989 are 3,050

new users (850 users in Oruro, 700 users in Potosi, and 1,500 users in La Paz). They are to be achieved through the three clinics (1,160 new users), the three CBD programs, and the affiliated physicians. CIES is recruiting affiliated physicians in Sucre who will contribute to the Potosi goal.

The 1989 actual figures are:

PIN 014-2	LA PAZ		ORURO		POTOSI	
	GOAL	ACHIEVED	GOAL	ACHIEVED	GOAL	ACHIEVED
Clinics	300	338	200	157	150	161
%		112.6%		78.5%		107%
Doctors	450	1,544	250	589	200	144
%		343%		235%		72%
CBD	700	716	450	723	400	270
%		102%		160%		67%
Total		2,598		1,469		575
GRAND TOTAL				4,642		

The El Alto program has a goal of 1,120 clinic users, 1,300 CBD users and 288 users in a small rural clinic administered by the El Alto clinic. The "mobile" clinic has a goal of 1,000 users for 1990.

Currently the La Paz clinic is underutilized, opening only two afternoons per week. By opening the remaining three afternoons, CIES could provide an additional 2,250 office visits per year. The personnel (a part-time physician and an auxiliary) would cost about $3,800 per year. By expanding operation hours in the La Paz clinic and investing in the laboratory and ultrasound equipment, CIES could be 10% financially self-sustaining during the first year. In the second and later years, financial self-sustainability could increase to 23% and even higher.

Organization Needs

An evaluation of CIES conducted by a Management Sciences for Health team indicated that the organization needed assistance in strategic planning and organizational development as well as training in program planning, management and evaluation. However, the evaluation praised CIES for its open communications with the government and "places of power".

Strategic planning: Although CIES has a three year plan the organization has difficulty in determining priorities. Because CIES has political connections with many unions who want it to provide services, it has the potential to reach a large segment of the population. Although CIES would like to help the unions, it must realize that it has both limited financial and human resources. Currently, the organization seems overextended for the number of personnel that it has. CIES should make sure that any additional activities complement existing ones and not provide a greater strain on the organization.

Financial management: Because each donor requires separate financial reports, a computerized accounting system would facilitate financial management. At present, PROSALUD (Santa Cruz) is conducting a consultancy to calculate (a) costs at clinics, (b) a market survey and (c) determination of prices to attain self-sustainability.

Clinic management: Currently the clinics' services arel6nderutilized. However, as the demand for reproductive health services increases effective use of clinic space and hours will become important. Joint training with IEC activities can make the clinics' waiting rooms a learning center.

Evaluation: CIES is interested in obtaining qualitative information through interviews and the use of focus groups. Although CIES has a well developed MIS, the integration of qualitative and quantitative information would enrich its evaluation process. Logistic support in this area is to be considered.

General Management: The organization is currently overextended it needs technical assistance in basic organizational management including the delegation of tasks and internal supervision.

Training: Because clinic operations are an integral part of CIES' operations, it is important that all receptionists, auxiliaries and physicians be trained in both contraceptive methods and interpersonal skills and counseling. Eventually, it may be helpful for the physicians to be provided with minilap training assuming that CIES offers this service in the future.

Personnel: In addition to technical assistance, CIES needs additional personnel if it is going to expand services. In addition to some six additional clinical personnel (three physicians and three auxiliaries), the organization needs another person to work with IEC and training and a half time person to work with administration. The laboratory and ultrasound equipment will generate revenues for CIES, and a vehicle would facilitate more regular monitoring and supervision of IEC and clinic activities.

6. FUNDACION SAN GABRIEL

Background

This institution was created in 1969 as an effort to assist a populous marginal zone in La Paz. They started with a health post and a day-care center. To date it has broadened greatly its scope of work and currently has ongoing work agreements with the Ministries of Health, Agriculture and Education as well as with international donors.

The objective stated in their constitution document is to improve the quality of life in the popular sectors through the provision of basic services and popular education, promote the participation of the communities for their empowerment and transfer appropriate science and technology to these sectors.

The financial sources for this institution are: (a) private German, Swiss and Spanish donors, (b) self-generated funds from their services, and (c) State contribution through salaries paid by the MOH to 20% of medical staff, and 40% of operating expenses for PHC attention from the Fondo Social de Emergencia. In 1987, they received some funding also from the Social Emergency Fund for infrastructure improvement.

Administrative structure

Fundación San Gabriel is a private non-profit organization legally registered as a foundation, whose assets would go to the Archbishop of La Paz if it ceased to exist. It has an agreement with the Ministry of Public Health whereby District 9 in La Paz city falls under their responsibility, covering around 164,000 inhabitants. In addition, many people in search of their good quality services and low pricing from other areas of the city are served by Fundación San Gabriel.

The Foundation is organized in five programmatic and one support area: (see organigram)

Health
Education
Community promotion and organization
Production
Training
Administrative and financial.

Each one of these areas has their specialized staff and is descentralized in their operations, and their administrative control due to different sources of funding, and therefore different financial reporting requirements.

In the health area, they have three levels of attention. Primary Health Care (PHC) is delivered through their 9 area clinics, and outpatient consultations. Secondary and tertiary attentions are delivered at the District Hospital. They also participate and carry on all the MOH interventions such as immunization campaigns, ORT, growth monitoring and nutrition.

The education area has its own programs such as those directed to day-care centers, school-age children, and street children. The area for the promotion and organization is basically directed to the education and training of women, it is funded by the Konrad Adenauer Foundation and Misereor. Within the area of the promotion of women, the health attention for women covers interventions related to reproductive health such as: cancer, STD detection, pediatrics, adolescents medicine, pre and post-natal care, deliveries, and family planning. The production area and the training areas are really support services with which the Fundación obtains some income, such as a print shop, a bread production center, a library, and a program for the practical training of last year medical students. Under this program and under an agreement recently signed with Harvard University, two MPH students will come in 1990 to undertake some practical work.

The research activities include clinical as well as behavioral studies related to their practice. Fundación San Gabriel also has a productive area whereby they train groups of women and young people in carpentry, print shop, and home gardens.

At the central level, the Fundación has a Directorate composed of the areas' Directors, and a Technical Directorate composed of Coordinators and Chiefs of programs. The general policy is defined at these levels as well as by work plans for each area. It follows the MOH general policy in the health area. An evaluation is prepared bi-annually by these bodies. The technical content of the inverventions is provided by the MOH. The Executive Director is a well-known physician with public health experience, who works in close coordination with the area directors.

Fundación San Gabriel follows the National Labor Code for hiring its personnel. 20% of their medical staff salaries comes from the MOH, and the other staff is financed via programs and projects from outside donors.

Physical resources and personnel

22% of the personnel are physicians, 30% nurses both graduate and auxiliary, 10% administrative and support staff, and the remainder are social workers, educators and promoters. The average continuity rate for their personnel is approximately 7 years.

Hospital San Gabriel has 105 beds, 16 outpatient clinics, a pharmacy, two laboratories and phisiotheraphy facilities. Their 9 community clinics are staffed with a physician, a nurse, a dentist and a promoter. The

percentage of bed occupancy is 70%, and the output per hour/physician is 7.8 patients for every 3 working hours. The District Hospital is about 70% self-sustainable, but the level of income for the other service areas is considerably lower. It is estimated that their overall self-sufficiency is increasing at a rate of 3% per annum.

Their plans for the future are to broaden and improve their Women and Family program, for which they are seeking assistance from USAID/B Reproductive Health Services Project. The Pathfinder Fund is beginning to work with them in the implementation of a youths' counselling and services clinic as part of the overall program.

7. PROSALUD

Background

PROSALUD was established by USAID in 1985 as a Self-Financing Primary Health Care Project to provide primary health care (PHC) to low income population living in peri-urban and rural areas of Santa Cruz. USAID/Bolivia and PL-480, Title III, provided the funding and Management Sciences for Health (MSH) from Boston the technical assistance.

Initially the project was designed to provide PHC services to members of three cooperatives, but was reformulated to provide these services to all types of community organizations

The overall goal of this project was to improve the health status, and thereby the productivity, of low-income rural and semi-urban workers and their families in selected areas of the Department of Santa Cruz. The major objectives of the project were to: 1/

a) Test the financial and operational feasibility of establishing self-financing primary health care services for low income persons in rural and semi-urban areas of Santa Cruz;

b) Establish a Management Support Unit (MSU) with the responsibility for overall management of the project and for post-project activities;

c) Test various health care service packages in order to arrive at ones most acceptable from the induvidual patient, client group, care-giver, and financial points of view, and to provide a dependable basis for possible replication.

An evaluation made of PROSALUD in October 1989 by Management Systems International (MSI) of Washington, D.C., concluded, among other considerations, the following:

"The PROSALUD project is one of the best examples of sustainable primary health care ever seen by the evaluation team and the program is close to reaching its goal of financial sustainability. In addition, the PROSALUD management team has succeeded in creating a PHC system which is technicall and culturally appropriate, as well as managerially sound. In fact, PROSALUD has succeeded in achieving all the elements outlined by AID as keys to the sustainability of any project, a significant accomplishment by any standards and one which few projects can claim." (page 4, final report).

Administrative structure

PROSALUD operates eleven urban and five rural medical centers and a central office and warehouse facilities. The service delivery covers a population of 140,000 inhabitants. The PROSALUD system as a whole has now attained (January 1989) a 95% self-financing level. This period included also the completion of an agreement between the Fondo Social de Emergencia and PROSALUD for the construction of 6 health centers in the urban areas of Santa Cruz. With those centers, currently under construction, the project will achieve its physical targets based on the projected revenues, for all existing centers, the self-financing targets will be very close to attain.

In Santa Cruz, PROSALUD is highly regarded as a health services provider. The Ministry of Health has turned over five rural posts for its administration, and the Municipal Government has donated funding for the construction of three new urban centers. Since 1988, through an agreement with PPIA, PROSALUD started incorporating family planning services within their PHC package, in response to existing demand.

Functioning

PROSALUD operates through a Directorate of nine members from outside the institution, who outline the policy and strategic issues.

The personnel that constitutes the MSU has been divided in two sectors: Executive Committee and Support Group.

Executive Committee

- Executive Director
- Director of Finances
- Director of Medical Services
- Marketing Director
- Chief of Training
- Chief of Pharmacy and Logistics

Support Group

- 1 Administrative Assistant
- 2 Secretaries
- 1 Chief of Personnel
- 2 Auditors and 1 Assistant
- 2 Responsible for warehouse
- 1 Driver
- 2 Janitors

The services provided by the MSU include activities that directly support the provision of health services, such as the location of new health centers, the organization of the beneficiary population, analysis of demand for services according to income, review of costs, monitoring of the services, marketing, training of personnel, annual planning and evaluation, etc. Other services are only indirectly related to the provision of health services, such as operations research, technical, management of information systems, epidemiological data, reports to Sanitary Units and Ministry of Social Welfare and Public Health. Finally, another group of services is oriented toward a complete different target population. These include technical assistance to other health organizations (public and private, national and international), consultant work, training, etc.

The technical personnel at the clinics is the following:

1	Medical Supervisor
12	Medical Diretors (one at each Center)
10	OB/GYNS
10	Pediatricians
11	Dentists
1	Biochemist
4	Laboratory Technicians
8	Registered nurses
45	Auxiliary nurses/promoters
11	Receptionists
2	Health technicians
12	Janitors/Porteros

Since January 1990, PROSALUD is providing infrastructure and logistical and administrative support to the Social Marketing Project (TFG). The SOMARC Coordinator is housed at PROSALUD, he has the support and guidance of PROSALUD's management, which would eventually undertake the whole project. PROSALUD earns an overhead of 20% of operating expenses for these services.

The medical directors of all the clinics have a monthly meetings to discuss the month's activities in both service delivery and financial management. There is also an annual strategic and operational planning meeting by the central management unit.

PROSALUD has produced a number of operational and personnel management manuals, and has developed a system of job grades for the purpose of structuring salaries, personnel contracts and evaluation forms and written procedures for selecting personnel. They have a functioning employee incentive scheme tying wages to the financial performance of each clinic, and avoiding the award of annual increases not linked to productivity. The revenues generated in the clinics are used to determine its performance and qualification for a bonus.

PROSALUD manages a pharmacy with a list of 134 items with a computarized system. A Quality Control Coordinating Committee reviews the use of pharmaceuticals every four months.

PROSALUD's service delivery system is composed by: Level I which are health promoters selected from the communities and trained (160 todate). Level II facilities or posts,basically rural, are staffed by a full-time auxiliary nurse. The Level III facilities are fully staffed with a full-time general physician, one graduate nurse, two nurse auxiliaries, one dentist and laboratory services. On a part-time basis, they have a lab technician, one ob/gyn and a pediatrician. These latter centers provide the following services: outpatient consultations in general medicine, ob/gyn, pediatrics, pre and post-natal checkups, pap smears, immunizations, pharmaceuticals, basic laboratory services, dental care, health education and training of promoters. Of these services, eleven are preventive health care interventions (out of 16). These consist mainly of nursing services which place a heavy burden on the financial side, and require substantial cross-subsidies from other revenue-generating activities.

In the area of reproductive health services, the identified needs for PROSALUD are:

a) Maintain the reproductive health services integrated within the PHC package offered at their centers;

b) Train their field personnel: physicians, nurses, auxiliaries in clinical as well as managerial aspects;

c) Conduct a research on the feasibility for self-sustainability for the reproductive health services delivery;

d) Research on social marketing techniques at their centers;

e) Start a CBD program from every medical center;

f) Produce promotional and educational materials for their activities;

g) Conduct operational researchs on their service delivery;

h) Train their personnel in scientific and natural family planning methods to offer a wider choice.

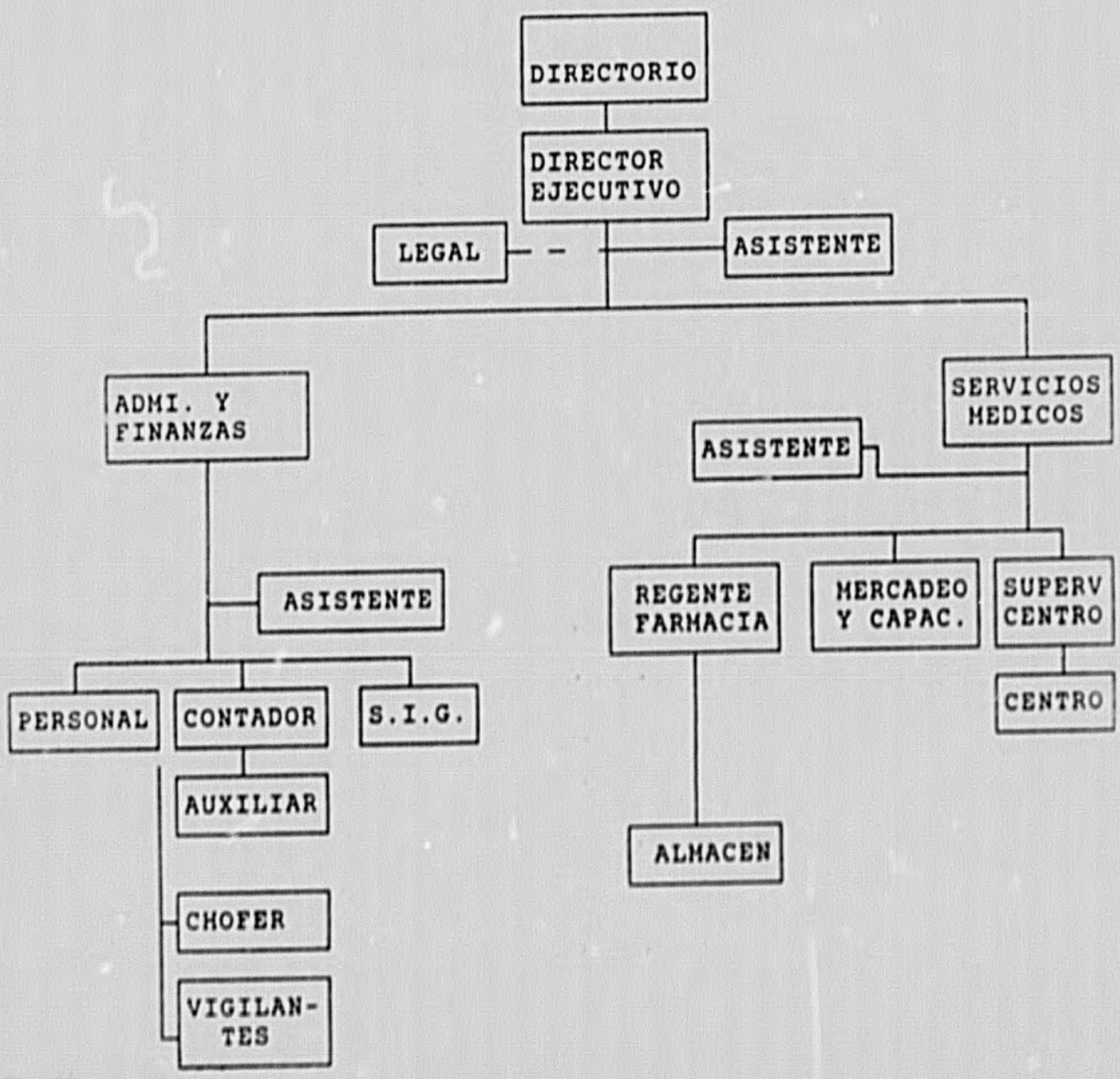
During the first phase, the project will provide PROSALUD with in-kind assistance through technical assistance in the areas of IEC, training and research. The service delivery will still be funded by FPIA under their current agreement (EOL-04) until the end of 1990. By that time, it is probable that these would have attained a certain degree of self-sustainability. Since August 1989, the project has been assigned its share of its income generation. Through eight months, the amount is Bs 3,840. These funds are kept in an interest-bearing account. The project will start phasing in for direct support of local costs, commodities and equipment currently provided under the FPIA agreement.

The current project with FPIA is to provide family planning services to 1,129 new and 452 continuing clients through nine established health centers and 804 new clients through the six newly established health centers in rural and urban Santa Cruz. They are also to refer 1,200 potential clients to the project health centers from 15 urban and rural communities. PROSALUD will try a new strategy with Promotional Assistants instead of Community Promoters, who will conduct home visits to promote the project services. She/he will be the link between the health center and its community offering referrals, delivery IEC talks and recruiting new clients.

1/ An evaluation of the Bolivian Self Financing PHC Project - MSI, Washington D.C., October 1989.

Wang 2938H

ORGANIGRAMA DE PROSALUD



ANNEX H

ADDITIONAL BUDGET INFORMATION

TABLE A

AID FUNDS

LIFE OF PROJECT SUMMARY COST ESTIMATES, BY YEARS (IN US$)

COMPONENTS	Year 1	Year 2	Year 3	Year 4	Year 5	TOTAL
I. SUPPORT FOR GOB ACTIVITIES						
a) CONAPO	30,000	80,000	84,000	110,000	96,000	400,000
b) IBSS/CNS	100,000	150,000	100,000	50,000	50,000	450,000
c) MOH/MCH	50,000	50,000	50,000	50,000	50,000	250,000
d) MANAGEMENT SUPPORT						800,000
1) PSC (Pop Officer)	41,600	41,600	41,600	41,600	41,600	208,000
2) PSC (Secretary)	20,800	20,800	20,800	20,800	20,800	104,000
3) Commodities	50,000†3	0	55,000	0	50,000	155,000
4) Evaluations & Audits	0	0	0	33,000	175,000	208,000
5) Logistic Support	25,000	25,000	25,000	25,000	25,000	125,000
	317,400	367,400	376,400	330,400	508,400	1,900,000
II. SUPPORT FOR NGO ACTIVITIES						
a) JHU/PCS	100,000	460,000	360,000	640,000	228,000	1,788,000
b) Pathfinder	200,000	250,000	300,000	150,000	100,000	1,000,000
c) Mothercare	150,000	200,000	125,000	125,000	100,000	700,000
d) Population Council	0	250,000	200,000	200,000	50,000	700,000
e) DAI	125,000	100,000	125,000	0	0	350,000
f) JHPIEGO	0	115,000	132,000	132,000	121,000	500,000
g) MSH/FPMT	125,000†1	150,000	125,000	50,000	50,000	500,000
h) TFG - Rapid III	150,000	150,000	150,000	0	0	450,000
i) TFG - Options	0	65,000	54,000	53,000	0	172,000
j) DHS †2	0	150,000	150,000	0	0	300,000
	850,000	1,890,000	1,721,000	1,350,000	649,000	6,460,000
III. CONTRACEPTIVE SOCIAL MARKETING						
a) SOMARC	150,000	250,000	282,000	158,000	100,000	940,000
T O T A L	1,317,400	2,507,400	2,379,400	1,838,400	1,257,400	9,300,000

Notes:

†1 FY 1990 OYB transfer to S&T/POP/TT, AID/W

†2 Total projected cost for 1993 DHS is $447,000, therefore it is anticipated that $147,000 will be provided by other international sources.

†3 FY 1990 BAT to S&T/POP/CPSD, AID/W

TABLE B

LOP SUMMARY OF COST ESTIMATES OF COMPONENT I: SUPPORT FOR GOB ACTIVITIES BY LINE ITEM

IMPLEMENTING AGENCIES	YEAR ONE FX	YEAR ONE L/C	YEAR TWO FX	YEAR TWO L/C	YEAR THREE FX	YEAR THREE L/C	YEAR FOUR FX	YEAR FOUR L/C	YEAR FIVE FX	YEAR FIVE L/C	TOTAL FX	TOTAL L/C	GRAND TOTAL
1. CONAPO													
a) Training	2,000	14,100	500	14,500	0	14,100	0	15,600	0	13,100	2,500	71,400	73,900
-Salaries		9,100		9,100		9,100		9,100		9,100	0	45,500	45,500
-Travel & perdiem		2,000		2,000		2,000		2,500		2,500	0	11,000	11,000
-Workshops		1,000		1,000		1,500		1,000		1,000	0	5,500	5,500
-Equipment	2,000		500								2,500	0	2,500
-Materials		1,000		400		500		500		500	0	2,900	2,900
-Publications		1,000		1,000		1,000		1,000			0	4,000	4,000
-Evaluation				1,000				1,500			0	2,500	2,500
b) Research	0	11,600	2,000	13,600	0	14,100	2,000	14,100	0	13,600	4,000	67,000	71,000
-Salaries		9,100		9,100		9,100		9,100		9,100	0	45,500	45,500
-Travel & perdiem		2,000		2,000		2,000		2,500		1,500	0	10,000	10,000
-Workshops				500		1,500		1,000		1,000	0	4,000	4,000
-Equipment			2,000				2,000				4,000	0	4,000
-Materials		500		1,000		500		500		500	0	3,000	3,000
-Publications				1,000		1,000		1,000		1,500	0	4,500	4,500
c) IEC	3,000	23,600	4,200	28,200	0	31,100	2,000	28,600	0	29,600	9,200	141,100	150,300
-Salaries		9,100		9,100		9,100		9,100		9,100	0	45,500	45,500
-Travel & perdiem		1,000		2,500		3,500		3,000		3,000	0	13,000	13,000
-Workshops		1,500		2,000		3,000		2,500		2,500	0	11,500	11,500
-Materials		1,000		1,600		2,000		2,000		1,500	0	8,100	8,100
-Equipment	3,000		4,200				2,000				9,200	0	9,200
-Publications		1,000		2,000		2,000		2,000		2,000	0	9,000	9,000
-Audience research				1,000		1,500				1,500	0	4,000	4,000
-Difussion costs		10,000		10,000		10,000		10,000		10,000	0	50,000	50,000
d) Policies	5,000	15,700	0	18,000	3,100	21,000	0	21,000	1,000	20,000	9,100	95,700	104,800
-Salaries		9,100		9,100		9,100		9,100		9,100	0	45,500	45,500
-Travel & perdiem		2,000		2,000		3,500		3,500		2,500	0	13,500	13,500
-Workshops		1,500		2,000		4,000		3,000		3,000	0	13,500	13,500
-Equipment	5,000				3,100				1,000		9,100	0	9,100
-Materials		1,300		500		1,000		1,000		1,000	0	4,800	4,800
-Publications		1,400		4,000		3,000		4,000		4,000	0	16,400	16,400
-Maintenance & repair		400		400		400		400		400	0	2,000	2,000
Subtotal	10,000	65,000	6,700	74,300	3,100	80,300	4,000	79,300	1,000	76,300	24,800	375,200	400,000
2. INSS/CMS													
a) Services	0	12,000	20,000	7,000	20,000	7,000	30,000	12,000	5,000	7,000	75,000	45,000	120,000
-Salaries											0	0	0
-Travel & perdiem		2,000		5,000		5,000		5,000		5,000	0	22,000	22,000
-Communications				2,000		2,000		2,000		2,000	0	8,000	8,000
-Equipment					20,000				5,000		25,000	0	25,000
-Commodities			20,000				30,000				50,000	0	50,000
-Office material		10,000						5,000			0	15,000	15,000
b) Training	10,000	7,100	0	24,000	3,000	22,500	0	25,000	0	19,500	13,000	98,100	111,100
-Salaries				10,000		10,000		10,000		6,000	0	36,000	36,000
-Travel & perdiem		1,500		4,000		5,000		5,000		5,000	0	20,500	20,500
-Workshops		5,000		5,000		4,000		5,000		3,000	0	22,000	22,000

-Equipment	10,000				3,000					13,000	0	13,000
-Materials		600		1,500		1,500		2,000	2,000	0	7,600	7,600
-Publications				2,000		2,000		1,500	2,000	0	7,500	7,500
-Evaluation				1,500				1,500	1,500	0	4,500	4,500
c) Research	0	4,900	2,000	13,500	0	14,500	2,500	14,500	0	8,500	4,500	55,900	60,400
-Salaries				6,000		6,000		6,000		0	18,000	18,000
-Travel & perdiem		1,500		2,500		3,000		3,500	3,000	0	13,500	13,500
-Workshops		2,000		2,000		2,500		3,000	2,500	0	12,000	12,000
-Equipment			2,000				2,500			4,500	0	4,500
-Materials		400		1,000		1,500		1,000	1,500	0	5,400	5,400
-Publications		1,000		2,000		1,500		1,000	1,500	0	7,000	7,000
d) IEC	3,000	13,000	2,000	31,500	0	33,000	5,000	36,500	0	34,500	10,000	148,500	158,500
-Salaries				10,000		10,000		10,000	10,000	0	40,000	40,000
-Travel & perdiem		1,500		3,000		5,000		5,000	5,000	0	19,500	19,500
-Workshops		3,000		3,000		3,000		4,000	3,000	0	16,000	16,000
-Materials		1,550		2,000		3,000		3,000	2,000	0	11,550	11,550
-Equipment	3,000		2,000				5,000			10,000	0	10,000
-Publications		750		1,500		2,000		3,000	3,000	0	10,250	10,250
-Audience research		1,200		2,000				1,500	1,500	0	6,200	6,200
-Difussion costs		5,000		10,000		10,000		10,000	10,000	0	45,000	45,000
Subtotal	13,000	37,000	24,000	76,000	23,000	77,000	37,500	88,000	69,500	102,500	347,500	450,000
3. MCH/FCH												
a) Services	10,000	6,000	10,000	6,000	10,000	6,000	10,000	6,000	10,000	46,000	34,000	80,000
-Salaries										0	0	0
-Travel & perdiem		3,000		4,000		5,000		5,000	5,000	0	22,000	22,000
-Communications				500		1,000		1,000	2,000	0	4,500	4,500
-Equipment	10,000		5,000		5,000				6,000	26,000	0	26,000
-Commodities			5,000		5,000		10,000			20,000	0	20,000
-Office material		3,000		1,500					3,000	0	7,500	7,500
b) Training	2,500	10,000	0	12,500		12,500	2,500	10,000	12,500	5,000	57,500	62,500
-Salaries										0	0	0
-Travel & perdiem		4,000		5,000		5,000		4,000	5,000	0	23,000	23,000
-Workshops		2,500		3,000		3,000		2,500	3,000	0	14,000	14,000
-Equipment	2,500						2,500			5,000	0	5,000
-Materials		1,500		1,500		1,500		1,500	1,500	0	7,500	7,500
-Publications		2,000		1,500		1,500		2,000	2,000	0	9,000	9,000
-Evaluation				1,500		1,500			1,000	0	4,000	4,000
c) Research	0	0	0	0	0	0	0	0	0	0	0	0
-Salaries										0	0	0
-Travel & perdiem										0	0	0
-Workshops										0	0	0
-Equipment										0	0	0
-Materials										0	0	0
-Publications										0	0	0
d) IEC	10,000	11,500	0	21,500	0	21,500	10,000	11,500	0	21,500	20,000	87,500	107,500
-Salaries										0	0	0
-Travel & perdiem		2,000		3,500		3,500		2,000	3,500	0	14,500	14,500
-Workshops		2,000		3,000		3,000		2,000	3,000	0	13,000	13,000
-Materials		3,000		3,000		3,000		3,000	2,000	0	14,000	14,000
-Equipment	10,000						10,000			20,000	0	20,000

-Publications		3,000		3,500		3,500		3,000		4,000	0	17,000	17,000
-Audience research		1,500		1,500		1,500		1,500		1,500	0	7,500	7,500
-Difussion costs				7,000		7,000				7,500	0	21,500	21,500
Subtotal	22,500	27,500	10,000	40,000	10,000	40,000	22,500	27,500	6,000	44,000	71,000	179,000	250,000
4. MANAGEMENT SUPPORT													
a) AID Project management Unit (PMU)		62,400		62,400		62,400		62,400		62,400	0	312,000	312,000
b) Commodities	50,000		0		55,000		0		50,000		155,000	0	155,000
c) Logistic Support		25,000		25,000		25,000		25,000		25,000	0	125,000	125,000
d) Evaluation and audits								33,000	175,000		175,000	33,000	208,000
Subtotal	50,000	87,400	0	87,400	55,000	87,400	0	120,400	225,000	87,400	330,000	470,000	800,000
GRAND TOTAL	95,500	216,900	40,700	277,700	91,100	284,700	64,000	315,200	237,000	277,200	528,300	1,371,700	1,900,000

ANNEX I

ENVIRONMENTAL THRESHOLD DECISION

Project Location	:	Bolivia
Project Title	:	Expansion of Child Spacing Services
Project Number	:	511-0568
Funding	:	$7.5 million (LOP)
Life of Project	:	5 years
OEE Prepared by	:	Raymond Victurine, USAID/Bolivia
Recommended Threshold Decision	:	Categorical Exclusion
Bureau Threshold Decision	:	Concur with Recommendation
Comments	:	None
Copy to	:	G. Reginald van Kaalte, Director USAID/La Paz
Copy to	:	John J. Cloutier, PD&I, USAID/La Paz
Copy to	:	Mark Silverman, LAC/DR
Copy to	:	Howard Clark, REMS/SA
Copy to	:	IEE File

Signed by: John O. Wilson Date: Feb. 23, 1989

John O. Wilson
Deputy Environmental Officer
Bureau for Latin America
and the Caribbean

INITIAL ENVIRONMENTAL EXAMINATION

1. BASIC PROJECT DATA

PROJECT LOCATION:	BOLIVIA
PROJECT TITLE:	Expansion of Child Services
PROJECT NUMBER:	511-0568
FUNDING:	FY89 $1,200,000 FY90 $ 450,000
LIFE OF PROJECT:	$7,500,000
IEE PREPARED BY:	Raymond F. Victurine Environmental Officer USAID/Bolivia
DATE PREPARED:	January 31, 1989

RECOMMENDATION FOR THRESHOLD DECISION

The purpose of the project is to increase access to voluntary family planning services. The goal is to improve the maternal and child health of Bolivia's rural and urbanpoor through the promotion of child spacing activities. This will be accomplished through the development of, access to, and use of quality family planning services.

The Project will include the following components:

1) delivery of family planning services including support to improve program management i both the public and private sectors;

2) IE&C activities and training to improve public awareness of population and family planning issues, user knowledge about contraceptive options, and the competence of service providers;

3) development of a policy dialogue, employing information generated through research in Bolivia (e.g. Demographic and Health Survey, operations research, and demographic models to assist in policy analysis) to link population growth to sustained development; and

4) research and evaluation activities to monitor progress and identify problems and lessons learned in the above three components.

Under Environmental Procedures for USAID, 22 CFR Part 216.2, Applicability of Procedures, Section (c) Categorial Exclusions, Number i.e, it states that an action that does not have an effect on the natural of physical environment is included in the class of actions for which an Initial Environmental Examination, Environmental Assessment and Environmental Impact Statement generally are not required.

In addition, under Part 216 (c) 2, it states that the following classes of action are not subject to the procedures set forth in 216.3 (General Procedures for Preparation of Initial Environmental Examinations and Environmental Assessments) except for the extent provided herein:

i. Education, technical assistance, or training programs, except to the extent such programs include activities directly affecting the environment (such as construction facilities, etc..) and;

viii Programs involving nutrition, health care or population and family planning services except to the extent designed to include activities directly affecting the environment (such as construction of facilities water supply systems, waste water treatment, etc.)

The project in question will provide technical assistance, training and education in the family planning sector, and no activities included in the project should have a direct effect on the natural or physical environment. As such, the project is eligible for a categorical exclusion as stated under 216 (c) 1.i and 216 (c) 2.i, and the Mission is not required to carry out an Initial Environmental Examination.

Based on the above, the Mission can render a negative environmental determination for this project.

Signed by: G. Reginald van Kaalte
G. Reginald van Kaalte
Director

Date: February 3, 1989

ANNEX J

DATA COLLECTION, MONITORING AND EVALUATION (M&E) PLAN

A. Introduction: The Reproductive Health Services Project will be focusing on five major activities: (1) Selected Reproductive Health Service Delivery Improvement, (2) Training, (3) Evaluation and Research, (4) Information, Education, and Communication, and (5) Policy Development. Given the number of organizations involved in the implementation of this project, the sensitivities associated with the activities, and evidence that family planning programs that include effective M&E systems achieve higher levels of contraceptive prevalence, the collection and use of performance data will be important for effectively managing the implementation of these activities and for ensuring that they will result in achievement of the project purpose.

The design will allow for a regular analysis of trends over time toward achievement of the project's goals and purposes. The point is not to expect to see goal or purpose achievement at any one point in time, but rather to ensure that observed trends indicate that movement in the desired direction is taking place. Periodic feedback on project effectiveness will flag problems as they arise and permit quick corrective action. Also, this design will provide a mechanism for signaling problems or issues that need further investigation (e.g., special studies).

The system described herein has been designed not only to meet Project implementation requirements, but also to satisfy longer-term Ministry of Health (MOH), Bolivian Social Security Institute (IBSS) and participating private Bolivian organizations' needs regarding the monitoring and evaluation of overall performance of reproductive health activities in Bolivia. The project's M&E system will rely to the extent possible on existing MOH, IBSS and other secondary data.

The Reproductive Health Services Project will undertake a wide array of monitoring and evaluation activities during the life of the project. A major element of the Reproductive Health Plan will consist of semi-annual reviews of COH, NGO and SMP program performance. Periodic monitoring activities will include (1) qualitative review of progress in attaining program objectives, (2) analysis of administrative and managerial efficiency, (3) assessment of cost effectiveness in program implementation and (4) appraisal of technical capabilities.

During the initial stages of implementation, a better understanding will exist regarding the types of data that are most essential and possible for managing the project. At that time, the managers and implementers of the project should make more definitive selections of data to be monitored. Periodically, throughout the life of the project, the managers and implementors of this project are encouraged to make appropriate modifications in this plan that reflect what is useful and possible. This document should, therefore, be viewed as an evolving plan.

B. Users of the Information: The primary users of the information generated by the M&E system will be the USAID/Bolivia Project Manager and the Mission's Health and Human Resources Office, relevant AID/W staff, the MOH, IBSS, the participating Bolivian organizations, and the U.S. Cooperating Agencies.

C. Institutional Locus: An important goal of the project will be to strengthen data collection, analysis and policy formulation capabilities in Bolivia. While the major evaluation studies for the Reproductive Health Services Project will be conducted by survey research organizations, USAID will encourage that public sector institutions engaged in basic data collection and research on reproductive health issues be further strengthened. In addition, USAID will manage the submission of semi-annual reports and reports resulting from special studies so that they are submitted according to schedule and that they follow a format that can easily be utilized for decision making (e.g. presentation of summarized data, issues, findings, conclusions, recommended actions).

D. Questions, Indicators, Data Collection Methods and Analysis

1. Project Goal: The goal is to improve maternal and child health.

a) Goal Level Question: To what extent has there been an improvement in maternal and child health?

b) Indicators: The following demographic indicators will be employed to measure success in achieving the overall goal.

- Infant mortality rate
- Maternal mortality rate
- Proportion of women hospitalized for abortion related complications
- Proportion of closely-spaced births

c) Data Collection Methods and Analysis: While the MOH currently collects mortality and morbidity data in each district, its reliability is suspect. The MOH, USAID and other donors are planning activities over the next few years to increase the reliability of health data. As reliability improves, the MOH's Health Information System will pick up more cases of infant, child and maternal mortality and morbidity and therefore, will show increasing mortality and morbidity rates. Thus, during the project's first few years, tracking changes in mortality rates will depend on other data collection sources.

The Demographic and Health Survey (DHS) will be conducted again in 1993. The DHS will cover the entire country and will be useful for tracking reductions in mortality and morbidity to which not only

this project will contribute, but to which several USAID child survival projects will also have contributed.

Considering the concerns (the high abortion rate and the adverse effect on women's health from the medical complications from abortions and high risk pregnancies) motivating the increasing acceptance of reproductive health activities by the the GOB and the religious groups, the project will monitor with greater frequency the proportion of hospital beds used for abortion-related complications and the proportion of closely-spaced births.

2. Project Purpose: The project's purpose is to increase access and quality of reproductive health services.

a) Purpose Level Question: To what extent has there been an increase in the use of reproductive health services?

b) Indicators: The following indicators will be used in evaluating the purpose of this project.

- Contraceptive prevalence among married women in fertile ages
- Number of active users of family planning methods (by type of contraception) using participating service delivery mechanisms
- Proportion of babies fully breastfed for at least four months

c) Data Collection Methods and Analysis: Changes in contraceptive prevalence will be monitored by a combination of methods. The national pre-implementation level of contraceptive prevalence has been measured by the 1989 DHS and will be measured again in 1993. With sampling in project areas, DHS should give a fairly good idea of the extent to which contraceptive prevalence has increased from the beginning of project activities to the end.

Managers and implementers of this project will not want to wait until the end of the project to determine the extent to which contraceptive prevalence has increased. Observing changes in contraceptive prevalence around project sites on an semi-annual basis will be important for ensuring that movement in the proper direction is taking place. Managers and implementators will then be in a position to know where performance needs to be improved and can take appropriate corrective action or provide fine-tuning to project activities throughout implementation. Such information, on a semi-annual basis, could also signal a need for further investigation to determine why expected progress is not being made or to understand why activities are more successful in some areas than in others.

The number of active users of family planning methods (by the type of contraception chosen) will be collected as part of service statistics at project site. After the establishment of a project MIS

by TFG/Options. The result of SOMARC's activities will be measured in Couple Years of Protection distributed. The USAID project manager will monitor this statistic over time to determine the extent to which demand is increasing in each of the sites. If the data show that demand remains low in general or particularly so in some sites, a special study may be initiated to explore what factors may be inhibiting demand. If some sites are showing particularly positive trends, it may be just as useful to initiate a study exploring those factors that may be contributing to success.

The proportion of babies fully breastfed for at least four months among project beneficiaries may be determined through an analysis of service statistics. Observing trends will provide project managers and implementers an idea of the extent to which the proportion of women utilizing the project's services are fully breastfeeding their babies for at least four months. As utilizers of the services, these women are presumably more aware than non-utilizers of the virtues of modern reproductive health practices and therefore make up a biased sample. Therefore, it is particularly important to watch that the proportion of these women that breastfed their babies fully for at least four months does not decline. If it does it should raise real concern for the general population. The DHS conducted in 1993 will also provide data on this indicator.

3. Project Outputs

The expected project outputs are increased access to selected reproductive health services and improved quality of services.

a) Output Level Question 1: To what extent has access (geographic, cultural and financial) to reproductive health services increased?

b) Indicators: The following output indicators will be employed to measure achievement of project objectives:

- Percent of MOH facilities in target health areas with maternal and child health services that include family planning services
- Percent of IBNS facilities nationwide with maternal and child health services that include family planning services
- Percent of participating local NGOs that continue to provide family planning services as part of reproductive health care
- Percent of participating local NGOs that regularly conduct community outreach activities and have outreach materials
- Percent of SOMARC outlets that offer the full range of pills and condoms in the program
- Percent of MWRA with knowledge of the high risk factors of pregnancy, contraceptive methods, and sources of supply
- Percent of service facilities with staff speaking the local indigenous language
- Reproductive health services and contraceptive prices not a barrier to use

c) Data Collection Methods and Analysis: Project outputs will be evaluated primarily through the same instruments used to assess the project goal and purpose; namely DHS surveys, MIS service statistics, NGO/SMP program performance data and USAID monitoring reports.

For example, data on the percent of MOH project facilities and IBSS facilities nationwide with maternal and child health services that include family planning services will be derived through an analysis of MOH and IBSS service statistics by facility. Further verification of this data will be supplemented by periodic site visits by the USAID Project Manager. The percent of local NGOs continuing to provide family planning services as part of reproductive health care and the percent of these NGOs which conduct community outreach activities and have outreach materials will be determined through an analysis of the PVO technical reports sent in to USAID. The percent of SOMARC outlets which offer the full range of pills and condoms offered by the program will be verified by analyzing SOMARC sales records by outlet and by periodic site visits to the outlets by the USAID Project Manager.

d) Output Level Question: To what extent has the quality of services improved?

e) Indicators: The following output indicators will be employed to measure achievement of project objectives.

- Technical competence of providers in providing clinical family planning services
- Adequacy and quality of information given to clients on methods available, their use, potential side effects
- Voluntary choice of family planning method by client within medical guidelines
- Number and variety of family planning methods offered at each site
- Interpersonal skills of service providers (client perceptions of interactions)
- Amount of time spent waiting in clinics

f) Data Collection Methods and Analysis: Project outputs will be evaluated primarily through the same instruments used to assess the project goal and purpose; namely DHS surveys, MIS service statistics, NGO (especially clinic-based programs) program performance data (qualitative and quantitative), special studies on quality of care issues, and USAID monitoring reports.

4. Project Inputs: The projects inputs cover the following areas: (1) Reproductive Health Services, (2) Training, (3) Research and Evaluation, (4) Information, Education and Communication, and (5) Policy Development.

a) Input Level Question 1: To what extent are the critical aspects of successful Reproductive Health Services present and functioning?

b) Indicators:

- Percent of clinics that have personnel providing reproductive services including family planning services
- Percent of clinics with minimum equipment needed to function effectively
- Percent of clinics with adequate reproductive health supplies (contraceptives and other)
- Percent of clinics with adequate educational materials for clients
- System-wide logistics system designed and percent of clinics for which it is operating

c) Data Collection Methods and Analysis: The percent of clinics that have personnel providing family planning services, the minimum equipment needed to function effectively, adequate supplies, adequate educational materials for clients and logistical systems that are designed and operating will be derived by an analysis of technical reports prepared by service providers. This information will be verified by periodic site visits by the USAID Project Manager. Evaluation teams will visit a representative sample of service facilities to measure these items.

d) Input Level Question 2: To what extent have training targets been met? What difference has the training made in the ability to perform? What training gaps remain for those who have received trai ing as well as for those who have not received training? What changes should be made in either the curriculum or type of training being offered?

e) Indicators:

- Number and percent of MDs in project facilities that have received training
- Number and percent of nurses working in project facilities that have received training
- Number of trainers trained
- Percent of participating service organizations with a trained trainer
- Number and percent of auxiliary nurses working in project facilities that have been trained
- Number and percent of community health workers associated with project facilities that have been trained
- Interpersonal Communications TOT workshop conducted
- Number of TOT workshop participants who received interpersonal skills training
- Conduct of follow on interpersonal skills workshops in 10 local institutions
- Number and percent of organizations and sites with trained managers

- Number of workshops, number of institutions involved, and number of persons trained in IEC skills
- Conduct of two workshops in operations research training
- Conduct of four workshops in evaluation training
- Number of pharmacy staff trained
- Number of pharmacy staff trained in refresher courses offered in FY 93 and FY 94
- Trained personnel are able to apply new skills in their work
- Trained personnel are able to perform their tasks more effectively
- Additional training needs identified for reproductive health personnel
- Needed changes in training curriculum identified

f) Data Collection Methods and Analyses: Information on the number and percent of project staff receiving training will be collected by reviewing reports received from each organization providing training and periodic site visits. This information will be tracked to determine progress being made in meeting training targets.

Information on the extent to which trained personnel are able to apply their new skills and perform more effectively and perceived training gaps will be reported on a semi-annual basis by supervisors of trained workers in each organization to the USAID Project Manager and discussed in a meeting with the training sub-committee of the National Project Coordinating Committee to determine changes and or additions to be made in either the curriculum or the type of training being offered. Outcome of training will also be measured at the purpose and output level as quality of services and the results of services are assessed.

g) Input Level Question 3: To what extent has the research and evaluation component resulted in a national MIS developed and functioning, and the design and implementation of routine evaluations, operations research on service delivery and behavioral/attitudinal studies. To what extent have the data resulting from this project component been used by participating organizations for decision making and improving delivery of selected reproductive health services?

h) Indicators:

- National MIS developed, agreed on, and adopted by all project participants and the resulting data is used for decision making
- Participating agencies routinely evaluate own programs and use results for decision making
- Number of operations research or other major evaluation studies conducted and results used by service delivery organizations for decision making
- Number of behavioral/attitudinal studies conducted and results used for decision making

i) Data Collection Methods and Analysis: Progress made on the development and adoption of a National MIS by all project participants will be verified by a combination of methods: review of devised data collection forms; reports on the percent of forms returned within 30 days of the deadline and through site visits. Once the MIS has been developed and adopted by all project participants, each organization will be asked to discuss decisions made based on the MIS data and submit this in reports to the USAID Project Manager.

The extent to which participating agencies are routinely evaluating their own programs will be measured by reviewing their technical reports and determining the extent to which it includes an analysis of service statistics and results from rapid appraisals conducted and recommended actions based on the data. In addition to the semi-annual reports, other evaluation reports will also be reviewed to determine progress made on this indicator.

The number and utility of operations research, evaluations and behavioral/attitudinal studies conducted will be measured by reviewing: proposals to AID/W, technical reports, final reports, dissemination activities and feedback from participating agencies on how they are using the results of the studies to improve their activities.

j) Input Level Question 4: To what extent has the information, education and communication component resulted in the development and wide distribution of materials and broadcasts that are necessary for educating the Bolivian population on the benefits, use and availability of reproductive health services?

k) Indicators:

- System in place for conducting an integrated IEC campaign on reproductive health for participating service providers
- Pamphlets and booklets on reproductive health and family planning methods designed, produced and distributed
- Number of pamphlets and number of posters to promote use of reproductive health services designed, produced and number of copies distributed
- TV, radio and video presentations for three campaigns designed, produced, distributed and broadcast

l) Data Collection Methods and Analysis: Progress made in putting a system in place to conduct an integrated IEC campaign on reproductive health for participating service providers will be determined by reviewing PCS and IEC Sub Committee Reports.

Progress made in designing, producing and distributing pamphlets and booklets on reproductive health and family planning methods will be determined by reviewing distribution records, making periodic site visits

to see whether pamphlets and booklets are visably available and the extent to which clients are taking materials, and through exit surveys to determine whether most clients are leaving with some educational materials.

Determining the number of pamphlets and posters designed, produced and distributed will be made by reviewing distribution records and by making site visits to assess whether materials are posted on walls for instructional purposes and whether an adequate supply is available for distribution to beneficiaries.

Progress made in designing, producing, distributing and broadcasting TV, radio and video presentations for three campaigns will be measured by reviewing PCS reports and actual monitoring of the broadcast media.

To ascertain how widespread this educational effort has been, women will be asked (during focus groups) if they have received any materials or heard any presentations on reproductive health on the TV or radio and if so, how if affected their ideas or choices regarding their own reproductive health.

m) Input Level Question 5: To what extent has the project's policy development component helped to create an environment supportive of the provision of reproductive health services?

n) Indicators:

Public policy process uses population data
Population data used by reproductive health organizations
MOH extends services to all women who request them
MOH explicitly supports international NGOs' provision of family planning information and services for health reasons

o) Data Collection Methods and Analysis: Determining the extent to which public policy process involves the use of population data and the extent to which a supportive environment has been created will involve doing a content analysis of GOB policy and deliberative documents, newspaper articles and public statements of GOB officials. A content analysis could be conducted periodically by a local social scientist.

Measuring the extent to which population data is being used by reproductive health organizations will involve a review of the organizations' strategic plans.

Measurement of the extent to which MOH is extending services to all women who request them will involve reviewing MOH service statistics, client records, and making site visits.

Measuring the extent to which MOH explicitly supports NGOs in their provision of family planning information and services will

involve a review of MOH policies and their correspondence with NGOs and public statements of MOH authorities.

E. Special Studies: This project will assist in the establishment of a MIS system for improving the quality of reproductive health service statistics. Support will also be provided to CONAPO in order to strengthen capabilities in population and development planning, and this project will also assist private sector evaluation and research efforts over the period 1990-1994.

For example, rapid, low-cost studies can be undertaken to examine differences between expected implementation plans and outcomes of project activities, where these outcomes are indicated by data generated by the on-going M&E system. Rapid, low cost studies can also be used to respond to special information requests and/or management questions which arise during implementation.

F. Feedback: Evaluation research reports will be carefully reviewed by USAID to ensure that data is reliably collected, responsibly analyzed and effectively disseminated. Efforts will be made to see that research findings are presented in a timely and concise manner that allows for their ready incorporation in program evaluation activities (including internal USAID quarterly, annual and final impact evaluations) and policy analysis oriented to the design of future reproductive health programs. In-country seminars and workshops will be sponsored in order to facilitate more effective dissemination of evaluation research findings.

G. Evaluation Schedule: The project's M&E system will track the project's progress toward meeting the project's stated goal, purpose, outputs, and inputs. A final evaluation will be conducted if (a) USAID decides to extend the project; in this case the evaluation will be carried out in time to inform the follow on design effort; and/or (b) project implementation experience and impact suggest that an indepth evaluation would be of value in documenting lessons learned.

Demographic and Health Survey will be repeated in 1993.

H. Principal Evaluation Research Activity:

- Strengthening MIS
- Operations Research and Diagnostic Studies
- IEC Evaluation Research
- Population and Development Planning
- Clinical Services Monitoring
- Research on improved service delivery including training resources.

ANNEX K

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CURRENT FAMILY PLANNING ACTIVITIES IN BOLIVIA

SECTOR	BOLIVIAN PROJECT GRANTEE	CONTRACTOR	FUNDING SOURCE PROJECT & NUMBER	PROJECT NUMBER	AMOUNT US$	DATES	DESCRIPTION
PUBLIC							
A. Policy	Consejo Nacional de Poblacion CONAPO - MPC Casilla 3116, LP Phone 359099 Lic.Rene Pereira Executive Secretary	The Futures Group 1101 14th St. NW. Washington, D.C. 20005 Technical Assistance: Research Triangle Inst. North Carolina	Mission PD&S CS funds buy-in to Rapid III 936-3046.01	511.0000.06	$100,539	August 1988 December 1989	Provide technical assistance to CONAPO to develop population projection models; purchase of equipment.
	CONAPO, La Paz	USAID/Bolivia	Mission PD&S Population and Child Survival	511.0000.05-90115 511.0000.06-90061	$15,184	July 1989 June 1990	Publication and diffusion of three population models: CS, Health and Women at high Reproductive Risk.
	CONAPO, La Paz	The Pathfinder Fund 9 Galen St. Watertown, Ma. 02172 Lima Regional Office Mr. Carlos Aramburu Regional Director	FP Services 936-3042	PIN-012-1	$35,700	April 1989 March 1990	Dissemination and Communication of population issues in Bolivia; diffusion of Conapo's works, mobile seminars, surveys of opinion.
	CONAPO, La Paz	Secretaria Ejecutiva de la PL-480 La Paz Carlos Brockman,Director	Title III		$95,000	August 1989 July 1990	Research on persistance and change of nutrition patterns and health care among pregnant women in 3 different contexts in Bolivia.
	Caja Nacional de Salud (CNS) La Paz Dr. Cesar Pereda Subcontractor: SINF. Victor Mezza Phone: 345686	John Short & Associates P.O. Box 1305 Columbia, Md. 21044 Phone (301)964-2811 Project TIPPS Karen Foreit, Lima	Mission PD&S Population	511.0000.05-3-00230 & 90032	$24,000	September 1988 May 1990	Conduct cost/benefit analysis of FP services at the CNS.
	Instituto Nal. de Estadisticas (INE) Antonio Gomez National Coordinator	Westinghouse Inst. for Resource Development(IRD) 8850 Stanford Blvd. Columbia, Md. 21045 Luis Ochoa, Coordinator	Demographic & Health Surveys (DHS) 936-3023		$267,000	July 1988 December 1989	National DHS sampling 8,500 HHs at urban and rural settings. Main indicators on health, fertility and contraceptive prevalence. Has also inputs from PAHO and UNICEF.
B. SERVICE							
i) Hospitals	Ministry of Health MCH Division Dr. Mario Pommier Director	USAID/Bolivia	Mission PD&S Population	511-0000.05-70016	$31,500	February 1987 December 1989	Provide FP services to women with incomplete abortions at public hospitals maternity services in several cities.
ii) Other	Empresa Nacional de Ferrocarriles (ENFE) Casilla 423	John Snow Inc. 1100 Wilson Blvd. 9th fl Rossiyn, Va. 22209	Enterprise Project 936-3034		$141,000	February 1988 April 1990	Railroad car mobile clinic for western region providing primary health care, FP and info to ENFE

CURRENT FAMILY PLANNING ACTIVITIES IN BOLIVIA

SECTOR	BOLIVIAN PROJECT GRANTEE	CONTRACTOR	FUNDING SOURCE PROJECT # NUMBER	PROJECT NUMBER	AMOUNT US$	DATES	DESCRIPTION
	La Paz Subcontract with CIS, La Paz	Maria Bousquets-Moura					employers and communities.
PRIVATE							
A. EDUCATION IEC/TRAINING	Bolivian PVOS and public institutions working in FP	Management Sciences for Health (MSH) 165 Allandale Rd. Boston, Ma. 02130	FP Management Training Project FPMT-936-3039 Laurel Cobb		$250,000	1988-1989	Short and long-term training for public and private Bolivian institutions working in FP.
B. SERVICES							
	Centro de Investigaciones Sociales CIS, A. Cisneros Casilla 6921, La Paz, phone 35293	John Snow Inc. Maria Bousquets-Moura	Enterprise Project 936-3034	Contract 1695-378-3701	$112,070	Sept. 1986 December 1989	For profit private sector counseling & service delivery in La Paz, Oruro, CBB. Trying to have employers assume costs of FP services.
	Centro de Orientacion Familiar (COF) Casilla 7522, La Paz Luis Llano, Director phone 3536340	IPPF/WHR 902 Broadway, 10th Floor New York, N.Y. Robert McLaughlin	Expansion & Improvement of FP Services 936-3043		$125,000	Triennial Plan 1987-89	Clinics in 7 Departaments, plus COF institutional support.
	Centro de Investigacion y Estudios Sociales CIES, La Paz Casilla 1452 phone 390011 Celia Taborga, Director	The Population Council One UN Plaza New York, N.Y. Lima Regional Office Jim Forest, Director	Operational Research 936-3030		$56,792	Sept. 1987 March 1989	OR on community-based distribution program with medical backup for union groups in La Paz and Oruro.
	CIES, La Paz Elizabeth Arteaga Director	FPIA Regional Office 8400 NW 52nd St. Miami, Fla. 33166 Teresa Mansfield Director	FPIA Program 932-0950	Bolivia-02 Modification	$59,000	May 1989 April 1990	Family life orientation clinic and CBD in seven urban-marginal sectors of El Alto, La Paz, and establishment of a new clinic in Viacha to serve rural areas.
	CIES, La Paz Bertha Pooley Director	The Pathfinder Fund Lima Regional Office Carlos Aramburu	FP Services 936-3042	PIN-014-2 PIN-014-3	$75,500 $136,164	October 1988 March 1990 April 1, 1990 June 30, 1991	FP and MCH services through 3 clinics in La Paz, Oruro and Potosi thru worker unions.
	CIES, La Paz Bertha Pooley Director	USAID/Bolivia	Mission PD&S Child Survival Funds	$11,000 (no-9007?	$14,160	June 1989 December 1989	Feasibility study to convert an OR project into service delivery.
	Clinica San Pablo Cochabamba Dr. Guido Iriga Director	Association for Voluntary Surgical Contraception (AVSC) LAC Regional Office Fernando Gomez, Director	AVSC Program 936-3049	BOL-07-OV-1-4	$16,368	Oct.1988 Sept 1991	Upgrade quality & safety of VSC Services. Fee of $10 for ex. operation for institutional costs; adds on local service.

CURRENT FAMILY PLANNING ACTIVITIES IN BOLIVIA

SECTOR	BOLIVIAN PROJECT GRANTEE	CONTRACTOR	FUNDING SOURCE PROJECT & NUMBER	PROJECT NUMBER	AMOUNT US$	DATES	DESCRIPTION
		P.O.Box 75405 Bogota, Colombia					
	Maternidad German Urquidi, Cochabba. Dr.Walter Salinas Director	AVSC/LACRO	AVSC Program 936-3049	BOL-08-SV-1A	$22,427	March 1, 1990 July 31, 1991	Initiate provision of high quality voluntary surgical contraception at Maternidad Urquidi in Cochabamba. Provision of equipment, training, IE
	Maternidad Percy Boland, Santa Cruz Dr. Mario Arano Director FP Services	AVSC/LACRO	AVSC Program 936-3049	Bol-09-SV-1A	$23,725	March 1, 1990 July 31, 1991	Initiate provision of high quality voluntary surgical contraception at Maternidad Percy Boland in Sta. Cruz Provision of equipment, training, IE
	PROFAMILIA Santa Cruz Dr. Carlos Cuellar Director	FPIA Miami Regional Office Teresa Mansfield Director	FPIA Program 932-0955 and Title III PL-480	Bolivia-04 Mod. 84	$84,147	March 1, 1990 February 1991	FP services incorporated in 9 urban and rural clinics, plus CBD program in Santa Cruz.
	Centro Radial de Orientacion Familiar CROF, La Paz Dr. Nancy Berrios Director	FPIA Miami Reg. Service	FPIA Program 932-0955	Bolivia-05	$6,200	1989 4 months	Daily radio spots on FP themes in native languages, plus a weekly 30 minute program.
	Fundacion Medico-Social (FAMES) La Paz Dr. Ruth Maldonado Director Edif.Hermann 1756	FPIA Miami Regional Office	FPIA Program 932-0955	Bolivia-06 Mod. 82	$75,000	February 1990 January 1991	FP service delivery in approx. 30 centers and a distribution network of 100 physicians in 6 Departments in the country.
	Centro Medico Cruz del Sur Cochabamba Casilla 527 Dr. Ivonne Frank Director	The Pathfinder Fund Lima Regional Office Carlos Aramburu Reg.Representative	FP Services 936-3042	PIN-013-1 PIN-013-2	$70,000	Oct. 1988 to Dec. 1990	Establish 4 FP/MCH clinics in Cochabamba. Second phase of 3-phase project including mass media, community talks and home visits.
	Sociedad Boliviana de Ginecologia (SBGO) Dr. José Larrea President Adembroth Importers Betanzos,Sta. Cruz	The Futures Group 1101 14th St. NW Washington, DC 20005 Santiago Plata Sara Tiffi, La Paz	Contraceptive Social Marketing (SOMARC) 936-3051		$409,000 $209,000	1987 through 1989	With the auspices of the SBGO, project conducts a sex education program and publicizes FP in the mass media (Betanzos); has introduced Norplay cycles in urban drugstores.
	SBGO	USAID/Bolivia	Mission PD&S Population Funds	511.0000-0-00-0012	$14,700	January to June 1990	Bridge funding for pilot survey of impact of SBGO's educational campaign and testing of new methodologies. 300 women at El Alto.

CURRENT FAMILY PLANNING ACTIVITIES IN BOLIVIA

SECTOR	BOLIVIAN PROJECT GRANTEE	CONTRACTOR	FUNDING SOURCE PROJECT & NUMBER	PROJECT NUMBER	AMOUNT US$	DATES	DESCRIPTION
					$2,495,194		

ANNEX L

MEMORANDUM DE ENTENDIMIENTO

ENTRE LA DIRECCION DE SALUD MATERNO-INFANTIL DEL MINISTERIO DE PREVISION SOCIAL Y SALUD PUBLICA EL CONSEJO NACIONAL DE POBLACION LA CAJA NACIONAL DE SALUD LA SOCIEDAD BOLIVIANA DE GINECOLOGIA Y OBSTETRICIA EL CENTRO DE INVESTIGACION, ESTUDIOS Y SERVICIOS SOCIALES LA ORGANIZACION PANAMERICANA DE LA SALUD USAID/BOLIVIA PARA LA CONSTITUCION DE UN COMITE NACIONAL DE COORDINACION DEL PROGRAMA DE SALUD REPRODUCTIVA DE USAID/BOLIVIA (1990-1994)

Entre la Dirección de Salud Materno-Infantil del Ministerio de Previsión Social y Salud Pública en la persona de su Director, el Dr. Mario Pommier, el Consejo Nacional de Población representado por su Secretario Ejecutivo Lic. René Pereira, la Caja Nacional de Salud, representada por su Director de Servicios Ginecológicos, Dr. César Peredo, la Sociedad Boliviana de Ginecología y Obstetricia, representada por su Presidente en ejercicio Dr. José Larrea Antelo, el Centro de Investigación, Estudios y Servicios Sociales (CIES) en la persona de su Directora Ejecutiva Lic. Bertha Pooley de Ormachea, la Organización Mundial de la Salud/Organización Panamericana de la Salud, representada por el Dr. Juan Manuel Sotelo, y USAID/Bolivia, representada por su Director el Sr. G. Reginald van Raalte, se celebra el presente Memorandum de Entendimiento para la constitución de un Comité Nacional de Coordinación que dirija, planifique, coordine y evalúe las acciones del Programa de Salud Reproductiva de USAID/Bolivia, sujeto a los Considerandos y Cláusulas siguientes:

CONSIDERANDO:

1. Que en fecha 25-27 de octubre de 1989, se realizó en La Paz un Taller en Planificación de la Salud Reproductiva, auspiciado por la División de Salud y Recursos Humanos de USAID/Bolivia, a objeto de presentar a discusión una propuesta de Programa de Salud Reproductiva que esta División piensa implementar en los próximos cinco años;
2. Que en dicha reunión participaron trece organizaciones internacionales y diecisiete locales, entre públicas y privadas, que en la actualidad tienen actividades relacionadas con la Salud Reproductiva en el país, entre las cuales se encontraban las que firman este Memorandum de Entendimiento;
3. Que en este Taller se emitieron recomendaciones para la ejecución del citado programa, entre las que figura de forma importante la necesidad de coordinación entre todas las instituciones del sector;
4. Que a objeto de poner en ejecución las recomendaciones de este Taller de Planificación en Salud Reproductiva;

ACUERDAN:

CLAUSULA PRIMERA: De la conformación del Comité Nacional de Coordinación

Establecer un Comité Nacional de Coordinación para el Programa, conformado por representantes de las instituciones participantes. En tal sentido, los miembros permanentes del Comité Nacional de Coordinación, con derecho a voto, serán:

- El Director de la División de Salud Materno-Infantil del Ministerio de Previsión Social y Salud Pública o su delegado;
- Un Representante del sector privado de servicios, o su delegado,
- El Secretario Ejecutivo del Consejo Nacional de Población (CONAPO) del Ministerio de Planeamiento y Coordinación o su delegado;

- El Director de Servicios Ginecológicos del Hospital Obrero de la Caja Nacional de Salud o su delegado;
- El Presidente en ejercicio de la Sociedad Boliviana de Ginecología y Obstetricia o su delegado;
- El Director de la División de Salud y Recursos Humanos de USAID/Bolivia o su delegado; y

En calidad de invitado especial y por representar a las organizaciones internacionales de asistencia técnica en salud:

- El Representante de la Organización Panamericana de la Salud o su delegado.

De acuerdo a la agenda a tratarse en alguna reunión y al criterio de los miembros, se podra contar con invitados especiales cuya contribución se considere importante para el Programa en una circunstancia determinada.

CLAUSULA SEGUNDA: Del objetivo y las funciones del Comité Nacional de Coordinación

El objetivo general del Comité Nacional de Coordinación es dotar de normas y políticas en la ejecución de las actividades de salud reproductiva para todas las instituciones y personas involucradas en el Programa, dentro de la normatización vigente del Ministerio de Salud Pública y de AID.

Las funciones del Comité Nacional de Coordinación, agrupadas en áreas de acción, serán las siguientes:

2.1) Dirección

El Comité Nacional de Coordinación se constituirá en rector de los programas y actividades del Programa de Salud Reproductiva de USAID. Para ello dotará de normas de atención, información e investigación aplicables a todas las actividades del Programa.

2.2) Planificación

a) El Comite Nacional de Coordinación definirá la contribución del Programa a las necesidades técnicas y financieras de las instituciones, dentro de las posibilidades y alcances del mismo.

b) Apoyará el desarrollo institucional, tanto de los participantes como de otras organizaciones interesadas que puedan ingresar al programa cumpliendo ciertos requisitos definidos tanto por el Ministerio de Salud Pública, División Materno- Infantil como por la División de Salud y Recursos Humanos de USAID/Bolivia.

c) Establecerá un sistema de adquisiciones y transferencias de suministros entre todas las agencias participantes, a fin de facilitar sus operaciones y no desaprovechar suministros que ya se encuentran en el país.

2.3) Coordinación

a) Asignará cuotas de participación y de responsabilidades comunes de los participantes.

b) Evitará la duplicación de servicios y materiales, tanto internamente como con otras agencias financiadoras.

c) Racionalizará y organizará la participación en actividades de capacitación de todos los participantes de manera equitativa y de acuerdo a las necesidades de las instituciones y del Programa en general.

d) Estudiará las solicitudes y recomendará el ingreso de nuevas instituciones locales o internacionales dentro del esfuerzo global del programa, bajo los criterios básicos propios de las entidades rectoras del mismo.

2.4) Supervisión y evaluación

a) Supervisará la ejecución de los diferentes proyectos y actividades del Programa.

b) Evaluará, directamente o a través de subcontratos, y a través del establecimiento de un sistema uniforme de indicadores, el progreso de las diferentes actividades.

CLAUSULA TERCERA: De los criterios básicos para la participación en el Programa

Los criterios básicos a los que se hace alusión en el inciso 2.3(d) de las funciones del Comité Nacional de Coordinación, se hallan establecidos en la reglamentación del Ministerio de Previsión Social y Salud Pública y de AID para estas organizaciones.

Estos criterios básicamente determinan que en la constitución de la organización no debe existir nada inconsistente con las metas y políticas del Ministerio ni de AID para la otorgación de su asistencia bilateral en este campo. Para este último caso, estas regulaciones están descritas en el Manual No. 13, apéndice 4D, pag. 53 sobre asistencia en planificación voluntaria de la población. Estos criterios mínimos de AID tienen que ver, principalmente, con los siguientes temas:

a) Participación voluntariamente consentida de los usuarios de cualquier método de planificación familiar;
b) Prohibición absoluta de entrar en actividades relacionadas con el aborto; y
c) La inelegibilidad para la asistencia bilateral de AID, de organizaciones privadas que ejecuten o promuevan el aborto.

Los criterios mínimos establecidos por la División de Salud Materno-Infantil del Ministerio de Salud Pública se encuentran detallados en el Programa de Salud Reproductiva (pag. 30) del Plan Nacional de Supervivencia-Desarrollo Infantil y Salud Materna (1989-1993).

CLAUSULA CUARTA: De los Subcomités Técnicos

Bajo la responsabilidad del Comité Nacional de Coordinación también estará la designación de cinco sub-comités técnicos con responsabilidades ejecutivas específicas, uno por cada uno de los componentes del programa, a saber:

1) Subcomité Técnico de Servicios

2) Subcomité Técnico de Información, Educación y Comunicación (IEC)
3) Subcomité Técnico de Capacitación
4) Subcomité Técnico de Investigación y Evaluación, y
5) Subcomité Técnico de Políticas de Población.

Estos sub-comités estarán conformados por personas especializadas en cada área del programa, representantes de las instituciones participantes, una de las cuales sería el/la consultor(a) que proporcionará la asistencia técnica específica, de parte de las agencias internacionales. Los subcomités estarán presididos por miembros del Comité Nacional de Coordinación o sus delegados, a saber:

4.1) El Subcomité Técnico de Servicios estará presidido por el representante del Ministerio de Previsión Social y Salud Pública ante el Comité Nacional de Coordinación o su delegado;

4.2) El Subcomité Técnico de Información, Educación y Comunicación estará presidido por el representante de la Caja Nacional de Salud ante el Comité Nacional de Coordinación o su delegado;

4.3) El Subcomité Técnico de Capacitación estará presidido por el/la representante de las organizaciones privadas participantes ante el Comité Nacional de Coordinación o su delegado;

4.4) El Subcomité Técnico de Investigación y Evaluación estará presidido por el representante de la Sociedad Boliviana de Ginecología y Obstetricia ante el Comité Nacional de Coordinación o su delegado; y

4.5) El Subcomité Técnico de Políticas de Población estará presidido por el representante del CONAPO ante el Comité Nacional de Coordinación o su delegado.

CLAUSULA QUINTA: Del funcionamiento y la Evaluación del Comité Nacional de Coordinación

5.1) El Comité Nacional de Coordinación se reunirá con una periodicidad mensual, y de manera extraordinaria según lo requieran las necesidades de éste y del Programa.

5.2) El Comité Nacional de Coordinación tendrá un año de vigencia a partir de su constitución, al cabo del cual será evaluado por sus miembros para su ratificación o reformulación, según lo requiera el caso, por el tiempo restante de duración del Programa.

5.3) El Comité Nacional de Coordinación estará dirigido por uno de sus miembros elegido para cada gestión anual.

5.4) El/la representante de la División de Salud y Recursos Humanos de USAID/Bolivia actuará de Secretario(a) Permanente del Comité Nacional de Coordinación y será responsable de su convocación y de la operacionalización de sus decisiones a través de los subcomités técnicos y de la propia División de Salud y Recursos Humanos, según el caso lo requiera.

CLAUSULA SEXTA: De la entrada en vigor, modificación, duración y terminación.

El presente Memorandum de Entendimiento entrará en vigor al ser firmado por todos los miembros del Comité Nacional de Coordinación y permanecerá en vigencia hasta la terminación del Programa de Salud Reproductiva.

El presente Memorandum de Entendimiento puede ser modificado o prorrogado por consentimiento mutuo por escrito de todos los miembros. Cualquier parte puede retirarse del presente convenio por aviso escrito a todas las demás partes, con treinta días de anticipación. Además, el presente Memorandum de Entendimiento puede ser terminado con respecto a todas las partes por consentimiento mutuo escrito por todos los miembros del Comité Nacional de Coordinación, con treinta días de anticipación.

EN FE DE LO CUAL, los suscritos, debidamente autorizados para tal efecto, firman el presente Memorandum de Entendimiento en seis ejemplares de igual tenor y validez en los lugares y fechas abajo indicados.

POR LA DIRECCION DE SALUD MATERNO-INFANTIL DEL MINISTERIO DE PREVISION SOCIAL Y SALUD PUBLICA
Dr. Mario Pommier
Director

La Paz,

POR EL CONSEJO NACIONAL DE POBLACION, MINISTERIO DE PLANEAMIENTO Y COORDINACION
Lic. René Pereira M.
Secretario Ejecutivo

La Paz, 12 Enero 1990

POR LA CAJA NACIONAL DE SALUD SERVICIOS GINECOLOGICOS
Dr. César Peredo A.
Director

La Paz,

POR LA SOCIEDAD BOLIVIANA DE GINECOLOGIA Y OBSTETRICIA
Dr. José Larrea Antelo
Presidente

La Paz,

POR EL CENTRO DE INVESTIGACION, ESTUDIOS Y SERVICIOS SOCIALES
Lic. Bertha Pooley de Ormachea
Directora Ejecutiva

La Paz,

POR USAID/BOLIVIA
G. Reginald van Raalte
Director

La Paz,

En calidad de invitado especial:
POR LA ORGANIZACION PANAMERICANA DE LA SALUD
Dr. Juan Manuel Sotelo
Representante

La Paz,

15 ENE. 1990

PROGRAMA DE SALUD REPRODUCTIVA

COMPOSICION DE LOS SUBCOMITES TECNICOS

Subcomité	Instituciones locales	Agencias de asistencia técnica
SERVICIOS	MPSSP/Materno-Infantil	Pathfinder
	Caja Nal. Salud	FPIA
	Fundación San Gabriel	JSI (Mother Care/FPLM)
	COF	TFG (SOMARC)
	SERVIFAM	
	PROSALUD	
	Organización Mundial de la Salud	
	Banco Mundial	
	USAID	
INFORMACION, EDUCACION Y COMUNICACION	Caja Nacional de Salud	JHU(PCS)
	SBGO	JSI (Mother Care)
	SERVIFAM	TFG (Somarc)
	CIES	
	COF	
	CROF	
	FAMES	
	USAID	
CAPACITACION	CIES	MSH(FPMT)
	MPSSP/MI	DAI (PAC IIB)
	Fundación San Gabriel	JHU (JHPIEGO)
	CIS	
	SBGO	
	FEPADE	
	PROSALUD	
	USAID	
INVESTIGACION Y EVALUACION	SBGO	Population Council (INOPAL II)
	CONAPO	TFG/DGI (Options)
	Maternidad Urquidi	IRD/Macro Systems
	CIS	
	CIES	
	FAMES	
	UNFPA	
	USAID	
POLITICAS DE POBLACION	CONAPO	TFG/RTI (Rapid III)
	MPSSP/MI	Pathfinder
	INE	
	Servicio de Cooperación Holandesa	
	USAID	

ANNEX M

AID/W COOPERATING AGENCIES AND CONTRACTORS TO BE SUPPORTED UNDER THE REPRODUCTIVE HEALTH SERVICES PROJECT

A. Population Communication Services (PCS), Johns Hopkins University

1. PCS Activities Worldwide

The purposes of PCS Project to develop effective information, education, and communication (IEC) programs in direct support of selected developing country population and family planning service delivery programs. The beneficiaries are developing country population/family planning service organizations with rural outreach programs and established service delivery facilities; fertile age couples.

Although many developing country couples are aware of the concept of family planning, they lack the information necessary to make an informed choice as to whether to practice family planning, when, and which method is most appropriate for them. This project provides country-specific assistance in the following: 1) identification of information and education needs of family planning programs; 2) marketing and audience surveys; 3) design, implementation and assessment of activities. These activities may range from small-scale studies for testing effective IEC methods, to larger-scale information campaigns, development, pretesting and revision of materials and methods; evaluation of effectiveness of IEC programs; and exchange and adaptation of IEC methods and materials between countries. The project emphasizes the use of both public and private sector organizations in developing countries engaged in information and education, and the development of IEC planning and implementation capability in developing country institutions. Through this project, translations and copies of effective materials and films are provided for population IEC programs.

The duration of the central project is from 5/29/86 - 9/31/91. A follow-on central project will be awarded in FY90.

2. Summary of PCS Involvement in Bolivia

JHU/PCS supported the Center for Family Orientation COP with an IEC project supporting FP services in eight cities (US $110,250 in local costs). The project resulted in a significant increase in clinic attendance without any negative public or political reaction, 1984 - 1987.

- JHU/PCS participated in the first Reproductive Health Planning Workshop from October 23-28, 1989 and submitted a revised IEC strategy and budget for the five-year project. Discussions were held with CIES, CONAPO and Cruz del Sur regarding preliminary project proposals, October, 1989.

- JHU/PCS received Mission buy-in totalling $US 235,000 ($143,200 in local costs and $91,739 in technical assistance) for IEC activities in support of the Reproductive Health Services Project - October, 1989.

- JHU/PCS staff visited Bolivia to work with CIES, CONAPO and Cruz del Sur to review preliminary project proposal and initiate activities. Also to meet with USAID/HHR team to discuss coordinating future JHU/PCS technical assistance with present communication activities - February, 1990.

3. PCS Activities Planned for Bolivia under the Reproductive Health Services Project

($1,788,000)

In order to improve the IEC effort which, in turn, will generate informed demand for reproductive health services in both the public and private sector, this activity will assist the participating institutions in systematically developing appropriate IEC messages and materials.

Based on previous IEC activities carried out in Bolivia, major interventions will be the following: (1) institutional strategy development; (2) training of trainers and interpersonal communication; (3) material design, production and distribution; (4) media campaigns; and (5) IEC research and evaluation.

In Year One, the IEC activities will focus on strengthening the IEC capabilities of the public and private sector family planning service providers. JHU/PCS staff will work closely with each agency to develop agency-specific communication strategies, improve interpersonal communication/counseling, and develop a comprehensive set of print materials to support all the family planning providers in informing clients. This will be achieved through: 1) training of trainers (TOT) interpersonal communication/counseling workshops; 2) hands-on training workshops in communication methodology; 3) design, pretesting and distribution of an integrated package of print materials, promoting the clinics, informing the clients, and assisting the clinic staff in counseling; 4) re-establishing a working group of IEC staff representing the most active family planning providers; and 5) develop materials appropriate to specific groups, such as policy makers and the press, to encourage dialogue and support of family planning services.

Once internal communication needs of each agency have been addressed, the emphasis in Year Two will be placed on wider clinic promotion, skills development in integrated media and continued IEC coordination. Specifically, to design, pretest, produce and evaluate : 1) inner-city bus cassettes; 2) videos for clinic waiting rooms; and 3) an integrated mass media campaign to promote specific family services and locations. Press liaison will be ongoing. In-depth research pertaining to attitudes, myths and fears will be carried out.

Follow-up training in both interpersonal communication/counseling skills and communication methodology will be offered to smaller family planning service providers in Year Three, or agencies working in secondary cities and the rural sector. Training videos in communication/counseling skills will be produced locally and reprinted with appropriate modifications and improvements. Innovative materials for the press and policy makers will be developed. Media campaigns focussing on special target audiences, such as men and young couples, will be produced. Audio-bus cassettes and radio spots will support the television spots and continue to promote clinic locations. Traditional folk media will be utilized to reach indigenous cultural groups. Communication research will be conducted to evaluate the cost-effectiveness of alternative IEC interventions.

Integrated media (mass media and folk media, as well as interpersonal communication) will be focussed to the special information needs of the diverse target audiences in Year Four (women, men, Aymara, Quechua, youth, leaders, press, informal sector, etc.) The development and dissemination of the family planning messages will be coordinated among the family planning groups. As in the previous years, each IEC activity will be evaluated. A final evaluation will take place in the last year of the project.

B. The Pathfinder Fund - Family Planning Services

1. Pathfinder Activities Worldwide

The purpose of Pathfinder activities is to introduce voluntary family planning services, information and training in developing countries, and to make existing family planning service systems more effective in both public and private sectors. The beneficiaries are rural and urban couples who gain access to comprehensive family planning information and services as a result of Pathfinder-sponsored projects.

The Pathfinder Fund is a nonprofit organization founded in Boston in 1957 to initiate and encourage family planning programs and activities throughout the developing world. Since A.I.D. funding began in 1967, the Pathfinder Fund has sponsored over 2,300 projects in 85 countries and has helped encourage the establishment of national family planning associations in several Asian and African countries. The Fund currently supports over 1151 projects in 25 countries. Activities include community based distribution programs, professional and paraprofessional training projects, clinical service programs, information and education projects, institutional development efforts, commodity and logistics support and youth programs.

The duration of this central project is from June 1985 - September 1991, with the expectation that a follow-on Pathfinder Cooperative Agreement will be approved after September 1991.

2. Summary of Pathfinder Involvement in Bolivia

- Dissemination and communication of population issues in Bolivia; diffusion of CONAPO's works, mobile seminars, survey of opinion, April 1989 - March 1990 ($35,700)

- Assist Cruz del Sur of Cochabamba establish four FP/MCH clinics. Project includes mass media, community talks and home visits, October 1988 - December 1990 ($78,000)

- Continuation of on-going service delivery in La Paz, Oruro and Potosi through three modalities (3 clinics, 65 community workers and 38 affiliated physicians) and extension to three established clinics in other mining and poor urban areas, October 1988 - June 30, 1991 ($231,664)

3. Pathfinder Activities Planned for Bolivia under the Reproductive Health Services Project

($1,000,000)

Building upon a solid working relationship with Bolivian PVOs since 1983, Pathfinder will continue and expand reproductive health education and services working primarily with Family Planning and Maternal Child Health Care Services in mining centers with CIES and IBSS/CAJA.

Pathfinder will collaborate with The Population Council (CONAPO) in the evaluation of the CIES program service delivery system to look at cost/efficiency and quality of services. Technical assistance and financial support will be provided for strengthening management and financial systems, including strategic planning, budgeting, development of administrative staff, and the dissemination of IEC materials for service projects, collaborating with FPMT/MSH and PCS/JHU respectively.

Conduct logistic/commodities workshops for participating agencies. The finding of a recent joint Pathfinder/JSI- technical logistics assistance visit to all Bolivian AID subgrantees will provide the frame work for the workshop curriculum. Areas such as contraceptive projections (CPT preparations) warehousing, record-keeping and reporting and contraceptive distribution will be emphasized. The logistics for the workshop will be handled by a local agency, Pathfinder, in collaboration with JSF, will provide technical assistance and training, plus technical assistance regarding the contraceptive commodity program in general.

C. Maternal/Neonatal Health and Nutrition (MotherCare)/John Snow, Inc.

1. MotherCare Activities Worldwide

The purpose of this project is to establish or improve services to mothers in developing countries through analysis of problems and the design of cost-effective interventions.

Services: - Delivery of interventions at primary/community level: tetanus toxoid, iron supplementation, dietary improvement, and management of maternal infections.

Conduct operational research on critical implementation issues

- Report on various research topics

The duration of this project is from FY 1988 - FY 1992.

2. Summary MotherCare Involvement in Bolivia

- MotherCare did an initial assessment and developed a preliminary proposal, describing a maternal care project that will provide an integrated package of prenatal, birthing and family planning services to women living in the urban and peri-urban areas of Cochabamba, November 1989.

- MotherCare participated in the USAID reproductive health workshop, October 1989.

3. Planned MotherCare Activities for Bolivia under the Reproductive Health Services Project

($700,000)

The purpose of this activity will be to provide a package of reproductive health services and information to low and middle income women, 15-45 years of age, living in and around the municipality of Cochabamba working with SERVIFAM, a local NGO.

MotherCare will provide technical assistance in detailed project design, communications, cost-financing, training, operations research and service delivery, MotherCare will be fully responsible for all necessary subcontracting and project administration and support a resident advisor. The buy-in will also provide funds for MotherCare to support the subcommittees on training and services, which plan to meet jointly in order to maximize coordination.

In Year One, MotherCare will focus on gathering information for qualitative investigation, prior to the development of communications and clinical intervention strategies. For example, an important community intervention proposed is the identification and training of traditional birth attendants.

During subsequent years, MotherCare will plan to up-grade existing SERVIFAM clinics and if demand increases, the addition of new clinic locations will be considered. Within this service, MotherCare will provide an expert in health care financing who will coordinate an analyses of the existing market for reproductive health services. Since the high cost of both public and private maternity services is seen as one of the principle causes of under-utilization, sliding fee scales and criteria for evaluation of clients will be established throughout the time period the short-term objectives of MotherCare will be:

1. Increase the knowledge and use of family planning methods that do not interfere with breastfeeding for limiting and spacing births.

2. Increase the proportion of women seeking prenatal care and receiving tetanus toxoid immunization during pregnancy.

3. Increase the proportion of deliveries attended by "trained" birth attendants. In the case of Bolivia, this could be a husband who has received special training, a TBA, a nurse or a physician.

4. Improve nutrition and other critical practices during pregnancy and provide iron/folate supplements to all pregnant women.

5. Improve the quality of breastfeeding, including its early initiation and exclusive nature, to enhance the child-spacing and protective effects of this traditional practice which is threatened in urban and peri-urban areas.

Long Term Objectives will include:

6. Decrease perinatal and neonatal mortality from preventable causes.

7. Decrease the rate of abortion and maternal mortality from this cause.

8. Decrease maternal morbidity and mortality.

D. The Population Council - Operations Research (OR) (I N O P A L II)

1. OR Activities Worldwide

The purpose of this project is to improve, through operations research, the quality, accessibility and cost-effectiveness of family planning and maternal-child health delivery systems in the developing world and to use operations research as a management tool to diagnose and solve service delivery problems. The beneficiaries are over 40 million persons served by delivery systems in which the project operates; most beneficiaries are rural.

This project provides short and long-term technical assistance and funding for design, implementation and with particular emphasis on evaluation of service delivery systems in developing countries. Health components focus on maternal and child health, e.g., oral rehydration, immunization and anti-parasite drugs for young children. Several projects are designed to test the acceptability and cost-effectiveness of natural family planning services.

The duration of the central project is from October 1989 to August 1992.

2. Summary of OR Involvement in Bolivia

The Population Council provided technical assistance and support to an operations research project on community based distribution with medical backup for union groups in La Paz and Oruro with CIES, September 1987 - March 1989 ($56,792).

3. OR Activities planned for Bolivia under the Reproductive Health Services Project

($700,000)

The Population Council will provide research and evaluation technical assistance, funding for operations research projects, and related administrative services as part of the Reproductive Health Services Project and the INOPAL II Project. Some activities planned include the following:

- To provide technical assistance to agencies to design, conduct, analyze, and disseminate the results of operations research projects

- To provide technical assistance to family planning agencies to evaluate information and service delivery activities

- To conduct four - six major operations research and evaluation projects in a four year period, as well as training courses and seminars

- To provide a forum for the dissemination of operation research project results and for the discussion of scientific topics related to family planning, child survival and population growth

- To address the need for institution strengthening additional activities will be supported; a local intern program for young Bolivian researchers and a resident advisor experienced in applied research in order to assure that the OR and evaluation activities will be conducted, disseminated and replicated, if successful, properly; and the Population Council will provide necessary support to the project subcommittees on policy and research

E. Development Associates, Inc. (DAI) Family Planning training for paramedical auxiliary and community (PAC) personnel II b

1. PAC IIb Activities Worldwide

The purpose of PAC IIb is to strengthen and develop the capacity of developing country institutions and agencies to design, implement and evaluate a program of training activities so that various PAC workers will be able to provide family planning services. The beneficiaries of this worldwide project are developing country regional and in-country family planning training institutions and programs, particularly the training staff of these programs; PAC personnel in assisted developing countries; developing country reproductive age couples who will receive improved FP and Maternal/Child Health services provided by those trained through the PAC II project.

The project provides assistance in training a wide variety of family planning paramedical workers including nurses, midwives, auxiliary and community workers, traditional practitioners and others. This training helps fill the immediate need for trained PAC workers in many countries, especially in Africa and the Near East. DAI supports the training need in Latin America. The project also places particular emphasis on assisting developing country institutions in all regions to develop the capability to carry on effective, technically self-sustaining family planning training programs for PAC workers. Assistance includes technical and other support to develop and strengthen family planning training institutions and programs; short-term technical assistance to supply specific technical training in on-going programs; and assistance in conducting training programs, assessing training results and incorporating the findings into subsequent courses. Project efforts concentrate on strengthening the skills of personnel who train, manage or supervise other PAC workers. The project emphasizes training in management/supervision, training of trainers, service delivery skills and pre-service preparation. Types and levels of assistance vary to meet needs specific to geographic regions and individual countries.

The duration of this project is from October 1989 - October 1994.

2. Summary of PAC IIb Involvement in Bolivia

- Under PAC II, DAI has provided technical assistance and training to several PVOs (CIES, PROSALUD, FEPADE) in community health worker areas, which included training in native languages, 1984 - 1988.

3. PAC IIb Activities Planned for Bolivia under the Reproductive Health Services Project

($350,000)

PAC IIb training needs assessment for Bolivia will be conducted. The training activities will be grouped into four categories:

1) Training of Trainers (TOT)
2) Training of Supervisors
3) Training of clinic-based paramedical and auxiliary personnel
4) Training of community promoters and distributors

The first of these, training of trainers, involves a series of activities, as the development of training skills and curricula cannot be adequately accomplished in a single short-term training event. The following sequence of activities for training trainers will be:

A two week training of trainers (TOT) course
A two-day followup for these trainers three months after the course
Another two-day followup for these trainers six months after the course
A one-week refresher training course one year after the initial TOT course

Two series of TOT activities will be conducted, each for twenty-five trainers from throughout Bolivia. One of these TOT series will be provided for trainers of clinic-based personnel, primarily public sector, and the other for trainers of non-clinical workers, primarily in private sector programs.

Because supervision is a critical element in the development of reproductive health programs, the courses will be offered for the clinic-based supervisors of auxiliary and paramedical personnel and for field supervisors and educators in private sector programs. Courses for supervisors would be for five days, covering both reproductive health content and supervisory skills.

Individuals trained as trainers would subsequently carry out training programs for others in their agencies. Trainers from clinic-based programs will conduct courses for nursing personnel in their institutions and private sector trainers will be primarily concerned with training community workers.

Thus, most courses in the last two categories of training will be conducted by trainers that participated in the training of trainers series. An exception would be on-going training activities conducted by CIES, FEPADE and PROSALUD, all of whom already have some training capability.

In the first two years, the remainder of FY90, and FY91, and possible for part of FY92 outside technical assistance will be required to carry out the TOT and supervisor training activities. In addition, part-time, in-country technical assistance will be available throughout the life of the project. The in-country advisor will coordinate all national and regional-level training activities, provide technical assistance in curriculum design and teaching methodology, and conduct followup and evaluation activities with trainers and other trainees.

F. Johns Hopkins Program for Internation Education in Gynecology and Obstetrics (JHPIEGO)

1. JHPIEGO Activities Worldwide

The purpose of the project is to train developing country physicians and nurses in family planning and reproductive health; to institutionalize appropriate training in developing country medical and nursing schools; and thereby to improve family planning service delivery. The beneficiaries are developing country physicians, nurses, educators, and administrators. Medical and nursing education institutions will also benefit, as will individuals and couples in developing countries who receive better family planning services.

JHPIEGO trains developing country physicians, nurses, and medical administrators in family planning and reproductive health. The training sites are primarily in developing country medical and nursing institutions. Three-week courses on specialized subjects are also held at JHPIEGO headquarters in Baltimore. Courses provides by JHPIEGO address: contraceptive methods, academic skills, sexually transmitted diseases, advances in

contraceptive technology, infertility, safe motherhood and child survival. Trainees and training activities are carefully chosen to lead to 1) institutionalization of reproductive health training in developing country medical and nursing schools; and 2) improved and expanded family planning services.

The duration of this project is from May 1987 - April 1992.

2. Summary of JHPIEGO Involvement in Bolivia

- JHPIEGO participated in the Reproductive Health Planning Workshop from October 23-28, 1989 and submitted a JHPIEGO strategy for Bolivia.

3. JHPIEGO Planned Activities for Bolivia under the Reproductive Health Services Project

($500,000)

JHPIEGO will collaborate in Bolivia to increase the number of health professionals in Bolivia with knowledge and skills in modern reproductive health care, especially family planning and child spacing services, particularly targeting post-partum women in the public sector.

Specifically, under this project JHPIEGO would hope to collaborate with the public sector through Women's Health training centers to establish a network which focuses on the non-pregnant woman using a reproductive risk approach. It is anticipated that over 600 MOH and social security physicians and auxiliary nurses will be trained.

In collaboration with three major medical/nursing faculties, JHPIEGO plans to develop a prototype curriculum based on major reproductive risk factors and major child survival interventions. In addition, there is a need for information via books, journals, films, videos and teaching models and for the development of a common consensus regarding what constitutes good medical practice in the reproductive health area in order to establish quality clinical training.

G. Family Planning Management Training (FPMT)/Management Sciences for Health (MSH)

1. FPMT Activities Worldwide

The purpose of this project is to strengthen the leadership and management of public and private family planning programs in developing countries by training senior and middle-level personnel. The beneficiaries are program leaders and mangers. Private and public family planning organizations will become more effective providers of service as a result of better program management, and individuals and couples will receive improved family planning services.

This project includes assistance for: (1) identifying specific management training needs in a country, and planning training activities to meet them; (2) training current program leaders, future leaders, and senior and middle-level managers; (3) follow up/technical assistance to trainees; and (4) developing training materials applicable to the needs of each region.

Project assistance for current and future program leaders helps them develop a broad perspective on population problems and their impact on development; an understanding of management issues in public and private-sector programs; and the ability to recognize and take action on management problems in the program. Project assistance for operational and technical managers helps to strengthen basic management abilities, including the knowledge and skills to resolve specific management issues in their programs.

The duration of this project is from September 1985 - September 1990. A new central project will be awarded in FY 90.

2. Summary of FPMT Involvement in Bolivia

(FY 90 OYB transfer $ 125,000)

FPMT/MSH has conducted short and long-term management training for public and private Bolivian institutions working in reproductive health, 1988-89 ($250,000).

- FPMT/MSH arranged Bolivian Study Tour to Brazil for eight persons to participate in the II Congreso Latinoamericano de Planificacionón Familiar, August 14-18, 1989.

- FPMT provided technical assistance and training to CIES to assist the sustainable institutional development of the organization. In addition, conducted an in-depth management needs assessment of CIES which lead to a management development plan, the plan identified and made recommendations for: (a) strategic planning; (b) organizational restructuring, including Board Development; (c) financial management systems; and (d) marketing FY 89-90.

- FPMT is providing technical assistance and training to Clínica Médica Cruz del Sur institutional development activities including organizational development, marketing analysis and strategic planning.

- FPMT conduct a management needs assessment of the family planning program of the Hospital Obrero and for IBSS in general, FY 1989.

3. FPMT Activities Planned for Bolivia under the Reproductive Health Services Project

($500,000)

FPMT would plan to continue to provide technical assistance and training in organizational development and management activities for reproductive health for both the public and private sectors. The major activities would include management development planning, market surveys, strategic planning and financial planning.

In order to assure proper implementation of this activity, FPMT will support a resident advisor and also provide funding for the functioning of the National Coordination Committee for the Project.

H. The Futures Group and Research Triangle Institute (R&T)

Resources for Awareness of Population Impacts on Development (RAPID III).

1. Rapid III Activities Worldwide

The purpose of this project is to raise awareness among national leaders about relationships between population growth and development and about the positive socio-economic and health effects of lower fertility. The beneficiaries will be host-country officials involved in development planning and policymaking.

The RAPID III project supports collaborative analyses of the implications of population growth for national development and health. Analyses also estimate family planning program requirements to meet expected future demand for services. Analyses utilize microcomputer-based simulations which project population growth under alternative fertility and family planning program assumptions. Integral to the RAPID III approach is the strengthening of local institutional capabilities for conducting population analyses. This is accomplished through technical training in US-based courses and country-based workshops, in addition to microcomputer transfer. The project support activities in over 25 countries with major emphasis on sub-Saharan Africa.

The duration of this project if from September 1987 - September 1992.

2. Summary of RAPID III Involvement in Bolivia

Provided technical assistance to CONAPO to develop population projection models; purchase of equipment, August 1988 - December 1989 ($100,539).

3. Rapid III Activities planned for Bolivia under the Reproductive Health Services Project

($450,000)

The Rapid III Project will be required in three areas, these include:

(1) Awareness raising focussing on key population issues and trends, emphasizing the health and economic benefits of providing reproductive health

services and the magnitude of unmet demand for these services. (2) Data organization emphasing the development of a data bank on demographic trends, socio-economic conditions and reproductive health. (3) Planning for implementation of the Bolivian reproductive health program, including data modeling and analysis. In addition, if funding is available, the RAPID III project would augment the activities of the Options project to develop the health/family planning information system.

The following studies will be conducted under each area:

Awareness Raising
(1) Secondary Analysis of 1989 DHS ($70,000)
(2) Family Planning Analyses ($80,000)
(3) Fertility and Child Survival Model ($60,000)
(4) Policy Awareness Presentation Models and Activities ($80,000)

Data Organization
(1) Data Base for Population/Family Planning Awareness and Planning ($57,500)

Planning
(1) Operational Model for National Plan for Child Survival - Maternal Health ($60,000).
(2) Santa Cruz Planning Models ($42,500)

I. Options for Population Policy (OPTIONS)

1. Options Activities Worldwide

The purpose of this project is to assist governments in developing national population policies, to assist public and private sector institutions in formulating operational policies for achieving national policy objectives; and to assist institutions in conducting policy analyses to support the development of national and operational policies. The beneficiaries include: Public sector: population councils, line Ministries, fiscal offices; Private sector: employers and professional associations, trade and labor organizations, research and policy institutes, and public interest groups.

Many developing country governments have expressed a need for technical support in their efforts to develop national population policies. This project responds to these needs by promoting activities leading to policy dialogue and policy reform. Project activities assist in developing plans for implementing national population policies as is now being done in Nigeria, Sudan and Zaire. In addition, assistance is provided to eliminate legal and regulatory barriers to family planning. The project provides assistance through the support of policy analysis subprojects, staff training, observational travel, and long-term advisors.

The options II project is expected to start October 1, 1990.

2. Summary of Options I Involvement in Bolivia

Initial assessment mission for CONAPO in the field of policy development, 1988.

3. Options II Project Activities planned for Bolivia under the Reproductive Health Services Project

($172,000)

The Options II Project will be required in 2 main areas:

(a) Development of strategic plans for the delivery of reproductive health services ($34,000). This would include analysis of infrastructure available to support alternative service delivery strategies; perceptions of contraceptive safety and efficacy and contraceptive mix; and determine level of activity by sector.

(b) Development of a management and information system (MIS) ($136,000) by evaluating the current system of collecting and processing human reproductive and other maternal child-health related statistics; evaluating hardware, software and human resources capabilities; developing a training strategy and a plan for implementing and monitoring of the system until it works satisfactorily to all parties.

J. Institute for Resource Development Inc. (IRD)/Macro Systems - Demographic and Health Surveys (DHS)

1. DHS Activities Worldwide

The purpose of this project is to conduct sample surveys of contraceptive knowledge, availability, and use and/or recent demographic levels and trends. The beneficiaries of the data generated by this project will be used by developing country governments to evaluate recent family planning and demographic levels and trends, and to improve programs for providing family planning and MCH services to the poor.

During the past several years A.I.D., through its support of the World Fertility Survey, Contraceptive Prevalence Surveys, and Birth and Death Data Collection projects, has been a leader in supporting sample surveys to provide this needed information. The Demographic and Health Surveys project carries on the most important functions of these projects. The primary objectives of DHS I have been to: a) provide financial and technical support to developing countries in conducting a total of 35 demographic and health surveys; b) disseminate survey results quickly to policymakers and family planning program administrators; and c) strengthen institutional capabilities in host countries for undertaking future surveys of this type.

Under DHS-II, IRD will: a) undertake a careful assessment of DHS data quality and future data needs; b) further improve the Integrated System for Survey analysis software and organize up to 10 Integrated System for survey Analysis workshops; c) conduct approximately 25 additional DHS surveys; d) disseminate DHS data via reports, conferences, special presentations, and distribution of data files; and e) promote further analysis of DHS data by host country researchers, program managers, and the international population and health communities.

The duration of this project is from August 1988 to August 1993

2. Summary of DHS Involvement in Bolivia

IRD provided technical assistance and support to INE to conduct a National Demographic and Health Survey (1989), sampling 8,500 married women of reproductive age at urban and rural settings, including main indicators on health, fertility and contraceptive prevalence, July 1988 - December 1989 ($267,000). Support for the survey will come from PAHO and UNICEF as well.

3. DHS Activities planned for Bolivia under the Reproductive Health Services Project

($300,000)

The 1993 DHS will be completed and dissemination activities will be conducted. The Buy-in from the Reproductive Health Services Project will be augmented by anticipated additional funds from other sources, e.g. UNFPA, UNICEF, PAHO, central-funds, etc.

K. The Futures Group - Contraceptive Social Marketing

1. Social Marketing Activities Worldwide

The purpose is to increase the availability and use of contraceptives among low and middle income groups in developing countries using commercial marketing and distribution techniques and to establish cost recovery schemes and targets in all sales programs. The beneficiaries are couples from developing countries who can pay for contraceptives and prefer to use the commercial sector for supplies, but cannot afford existing prices.

Contraceptive Social Marketing (CSM) projects use the techniques and resources of commercial enterprises to meet the social goal of making contraceptive supplies and information more widely available. The CSM I project has four main functions: 1) to provide technical and financial assistance to design and implement new country programs; 2) to provide short-term technical assistance to ongoing CSM programs; 3) to conduct special studies to improve the implementation of and expand the understanding of the dynamics of social marketing activities; and 4) to collect, analyze, and disseminate technical information among CSM programs, family planning

professionals, A.I.D. officials, and developing country policymakers. CSM II incorporates activities initiated under CSM I and consolidates established programs and expands sales programs, particularly in Africa. Countries in Latin America, Asia and Near East with more sophisticated infrastructure and more mature family planning programs will be assisted in becoming financially independent, while newer programs will be provided greater assistance in market research policy and training. The project will also maintain a central management information system for all A.I.D. financed CSM programs.

The duration of CSM II is from - September 1988 - September 1993.

2. Summary of SOMARC Involvement in Bolivia

Under the auspices of the SBCO, the SOMARC project conducts a sex education program and publicizes family planning in the mass media and has introduced Noriday cycles in urban drugstores, 1987 through 1989 ($409,000).

3. The Futures Group - SOMARC Activities Planned for Bolivia under the Reproductive Health Services Project

($940,000)

The goal of the Bolivia Contraceptive Social Marketing Program is to increase awareness of family planning and correct use of modern contraceptive methods. A second project goal is to promote a similar increase in awareness and availability of modern contraceptives and their correct use among rural Bolivian men and women.

The project objectives are to increase knowledge and use of all brands of oral contraceptives, IUDs, and condoms through the CSM program's commercial distribution efforts, and advertising and information campaigns; an anticipated 215,333 new couple years of protection (CYP); reduce overall costs per CYP; to increase consumer access to low-cost, high quality contraceptives through the program's commercial product distribution and sales efforts. Sales projections of project products till 1993 are as follows:

- 186,000 cycles of Noriday
- 207,000 cycles of Micro-Nor
- 150,000 cycles of Trinovum
- 738,000 condoms
- 3,250 Copper-T 380A IUDs (introduction under study)

In addition SOMARC will carry out appropriate research and evaluation activities. For example, conduct twice-yearly audits of 80 pharmacies in La Paz, Cochabamba and Santa Cruz, to measure the existence and sales levels of various brands and methods of contraceptives and carry out focus group studies of Micro-Nor packaging and insert. An in-country, management/resident advisor will be in place to provide on-going, daily attention to the implementation and institutionalization of SOMARC activities.

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ANNEX N

REFERENCES

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