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

PROJECT PAPER

BURMA - PRIMARY HEALTH CARE

USAID/Burma

1980

UNCLASSIFIED

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

PROJECT AUTHORIZATION

BURMA

Primary Health Care
Project No. 482-0002

Pursuant to Section 104 of the Foreign Assistance Act of 1961, as amended, and the Delegations of Authority thereunder, I hereby authorize the Primary Health Care Project (the "Project") for Burma (the "Cooperating Country"), involving planned obligations of not to exceed \$5 million (\$5,000,000) in grant funds (the "Dollar Grant") and not to exceed 9,498,000 excess U.S.-owned Burmese kyats (One Million Four Hundred Sixty-Two Thousand Dollars [\$1,462,000] equivalent) also in grant funds (the "Kyat Grant") over a two-year period from the 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 Project is designed to assist the Cooperating Country in expanding the coverage and quality of Burma's Primary Health Care System in approximately 147 of 287 townships. This will be done through: increasing the availability of trained primary health care workers; improving and expanding supervision of primary health care workers; expanding the range disease control activities carried out by primary health care workers; strengthening support and referral services available at health centers and station hospitals; and increasing the capability of health services to monitor primary health care and basic health services programs.

The project agreement(s) which may be negotiated and executed by the officer to whom such authority has been delegated in accordance with A.I.D. regulations and delegations of authority shall be subject to the following essential terms and major conditions, together with such other terms and conditions as A.I.D. may deem appropriate:

a. Conditions Precedent to Execution of Project Agreement

Prior to execution of a project agreement, there shall have been received from the Cooperating Country an official request for the assistance. If such request covers only the Dollar Grant but not the Kyat Grant, the project agreement may be executed on the basis that the U.S. contribution will be the Dollar Grant, with the Cooperating Country contributing an amount equal to and in lieu of the Kyat Grant, in addition to contributions otherwise planned to be made by the Cooperating Country for the project, provided that, if A.I.D., after execution of such project agreement (but not later than the Project Assistance Completion Date, including any extension) receives from the Cooperating Country an official request for the Kyat Grant, the agreement may be

appropriately amended to include the Kyat Grant from the U.S. and to reduce the Cooperating Country's equivalent contribution so that, in effect, the earlier-committed Kyat from the Cooperating Country will have served the function of an advance until the establishment of the Kyat Grant from the U.S. Expenditures thus in effect advanced out of Kyat funds provided by the Cooperating Country may be reimbursed from the Kyat Grant to the extent such expenditures conform to the terms of the project agreement, including amendments thereto.

b. Source and Origin of Goods and Services

Except for ocean shipping, goods and services financed under the A.I.D. Grants shall have their source and origin in the Cooperating Country or in the U.S., except as A.I.D. may otherwise agree in writing. Training may be undertaken in the U.S., in third countries, or in the Cooperating Country, in accordance with the provisions of A.I.D. Handbook Number 10. Except as A.I.D. may otherwise agree in writing, ocean shipping funded by A.I.D. under the Project shall be financed only on flag vessels of the United States.

The agreement shall contain a provision to the effect that, prior to any disbursement, or the issuance of any commitment documents under the project agreement, for the procurement of commodities, the Cooperating Country shall budget or otherwise provide evidence satisfactory to A.I.D. of the availability of sufficient funds to pay any duties or taxes levied against the commodities financed by A.I.D. under the project or it shall provide evidence satisfactory to A.I.D. that a waiver has been granted excepting A.I.D.-financed commodities from such duties or taxes.

c. Covenants

The Cooperating Country shall covenant to the effect that it will expeditiously process and properly store and distribute all commodities financed under the Grant.

Clearances

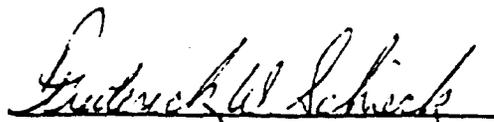
ASIA/PD: DJBrennan
ASIA/ISPA: DChandler
ASIA/DP: RHalligan
GC/ASIA: HMorris
ASIA/TR: TARndt (Draft)

Date

Initial

8/14
8/15
8/15
8/15




Frederick W. Schieck
Acting Assistant Administrator

August 15, 1980
Date

PROJECT DATA SHEET

Revision

COUNTRY/ENTITY: BURMA
 3 Project Number (7 Digits): 482-0001
 4. BUREAU/OFFICE: Asia A. SYMBOL: ASIA B. CODE: 04 5. PROJECT TITLE (MAXIMUM 40 CHARACTERS): Primary Health Care
 6. PROJECT ASSISTANCE COMPLETION DATE (PACD): MM 09 DD 31 YY 83 A. INITIAL FY: 810 B. QUARTER: 3 C. FINAL FY: 81
 (ENTER 1,2,3,OR 4)

8. COSTS(\$000 OR EQUIVALENT \$1-)

A. FUNDING SOURCE	FIRST FY			LIFE OF PROJECT		
	B FX	C - LC	D TOTAL	E FX	F LC	G TOTAL
AID APPROPRIATED TOTAL						
GRANT	2000		2000	5000		5000
LOAN						
OTHER	1. US-owned					
U.S.	2. Kvats					
HOST COUNTRY		2014	2014		5460	5460
OTHER DONOR(S)	2122		2122	4669		4669
TOTALS	4122	2698	6820	9669	6922	16591

9. PROPOSED BUDGET AID FUNDS (\$000)

A. APPRO. PRIATION	B. PRIMARY PURPOSE CODE	PRIMARY TECH. CODE		E. 1ST FY 80		H. 2ND FY 81		K. LIFE OF PRO	
		C. GRANT	D. LOAN	F. GRANT	G. LOAN	H. GRANT	J. LOAN	L. GRANT	M. LOAN
(1) HE	533-B	510		2000		3000		5000	
(2)									
(3)									
(4)									
TOTALS		2000		3000		5000			

10. SECONDARY TECHNICAL CODES (MAXIMUM SIX CODES OF THREE POSITIONS EACH): 562 350
 11. SECONDARY PURPOSE CODE

12. SPECIAL CONCERNS CODES (MAXIMUM SEVEN CODES OF FOUR POSITIONS EACH)
 A. CODE: DEL/NUTR TNG
 B. AMOUNT: 2175 4284

13. PROJECT PURPOSE (MAXIMUM 480 CHARACTERS)
 [This project will assist the Government of the Socialist Republic of the Union of Burma (GSRUB) to expand the coverage and quality of Burma's primary health care system in 147 of the country's rural townships.]

14. SCHEDULED EVALUATIONS
 INTERIM: MM 04 YY 81 MM 04 YY 82 FINAL: MM 04 YY 83
 15. SOURCE/ORIGIN OF GOODS AND SERVICES
 000 LOCAL
 941 OTHER (SPECIFY) 935

16. ORIGINATING OFFICE CLEARANCE
 SIGNATURE: David N. Merrill
 TITLE: David N. Merrill, AID Representative
 DATE SIGNED: MM 12 DD 23 YY 79
 17. DATE DOCUMENT RECEIVED IN AID/W, OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION
 MM 12 DD 23 YY 77

18. AMENDMENTS/NATURE OF CHANGE PROPOSED

ABBREVIATIONS

AID/W	Agency for International Development, Washington
AMW	Auxiliary Midwife
BHS	Basic Health Services (see Glossary)
BPI	Burma Pharmaceutical Industries
CHP	Country Health Programme
CHW	Community Health Worker
CMSD	Central Medical Stores Division
D/S	Division/State
D/STT	Division/State Training Team
DG	Director General
DOH	Department of Health
DPSC	Defense Personnel Supply Center
EPI	Expanded Programme for Immunization (Project)
FERD	Foreign Economic Relations Department, Ministry of Planning and Finance
FHC	Family Health Care (Project)
FNDH	Foreign National Direct Hire
GSRUB	Government of the Socialist Republic of the Union of Burma
HA	Health Assistant
IMR	Infant Mortality Rate
LHV	Lady Health Visitor
MCH	Maternal Child Health
MOH	Ministry of Health
MOPF	Ministry of Planning and Finance
MW	Midwife
PHC	Primary Health Care (see Glossary)
PHN	Public Health Nurse
PHS	Public Health Supervisors I and II
PIO/C	Project Implementation Order/Commodities
PIO/P	Project Implementation Order/Participant Trainees
PIO/T	Project Implementation Order/Technical Services
RHC	Rural Health Center
TA	Travel Allowance
TBA	Traditional Birth Attendant
THO	Township Health Officer
TMO	Township Medical Officer
TMP	Traditional Medicine Practitioner
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Devel- opment, Rangoon
USDH	United States Direct Hire Employee
VBDC	Vector-Borne Disease Control (Project)
VPC	Village Tract People's Council
WHO	World Health Organization

GLOSSARY

- Anade** - Character trait ascribed to Burmese which includes gratitude, respect and consideration for others, especially elders, self-restraint, and unwillingness to give offense or show aggression.
- Basic Health Services** - The most peripheral level of the formal Burmese health structure. In the context of this project, it includes Rural Health Centers and subcenters, all of which are staffed by full-time, paid para-professional health workers.
- Let-the** - Burmese traditional birth attendant, usually a middle-aged or older woman with limited or no education. Let-thes are responsible for a major share of deliveries in rural Burma today, and they usually receive some form of payment for their services.
- Nat** - Class of supernatural beings which are more powerful than man and are believed to effect good or evil in people, and to cause several types of illness, especially mental illness.
- Primary Health Care** - The limited health care provided by non-professional workers who are not employed by the formal Government health structure. Although they may receive some form of payment for their services, they are normally selected from and responsible to their own communities. In the context of this project, primary health care workers include auxiliary midwives, community health workers, and let-thes. (Care should be taken to avoid confusion with the GSRUB Primary Health Care project (PHC) which includes only CHWs.)

BURMA
PRIMARY HEALTH CARE
PROJECT PAPER

I. SUMMARY AND RECOMMENDATIONS

A. COSTS

Total project costs are as follows:

AID Grant*	6,459,000
UNICEF	3,744,000
WHO	925,000
GSRUB Budget**	2,155,000
Community Contributions**	3,305,000
Total:	<u>16,588,000</u>

(*Includes \$1.459 million of US-owned excess kyat;
** In US dollar equivalent at \$1 = Kyat 6.5.)

B. PURPOSE

The project will assist the GSRUB in expanding the coverage and quality of Burma's primary health care system in 147 of Burma's rural townships. This will be done through:

- increasing the availability of trained primary health care workers,
- improving training and supervision of primary health care workers,
- expanding the range of disease control activities carried out by primary health care workers, with particular emphasis on nutrition, diarrheal disease, antenatal and child care, and malaria,

- strengthening supporting and referral services available at rural health centers and station hospitals, and
- increasing the capability of the health services to monitor and evaluate the primary health care and basic health services program.

C. DESCRIPTION

The project has two major reinforcing components: (1) pre - and in-service training for primary health care workers, and (2) providing supplies and equipment to primary health care workers, as well as station hospitals and rural health centers. Participant training and advisory service components support these activities.

D. ANALYSES

The analyses in the project paper conclude that the project is technically, financially, and socially feasible and that planning is sufficiently developed for implementation to begin.

E. IMPLEMENTATION

The Government of the Socialist Republic of the Union of Burma (GSRUB) will be the Grantee. The Ministry of Health, however, will be the implementing agency.

F. WAIVERS

In order to effect substantial cost savings, as well as compatibility between AID-financed and other commodities, a code 935 waiver to permit procurement from UNICEF will be justified at the time of project authorization. In addition, it is proposed that U.S.-owned excess kyat be used to support all local costs as part of the grant.

G. STATUTORY REQUIREMENTS

Project-specific requirements have been met

H. ISSUES

With a few exceptions, PID issues have been satisfactorily addressed; selected outstanding issues which remain to be resolved during the course of project implementation are discussed in the technical, financial and social analyses.

I. RECOMMENDATIONS

That the project paper be approved and that AID assistance be authorized under grant funding to the GSRUB, as soon as possible.

Note: The project is the result of a GSRUB initiative and represents an add-on to and expansion of an on-going Department of Health project. Project development was assisted by an AID-funded team from Management Sciences for Health (MSH), and much of the substance of the project paper is derived from the work of the MSH team.

II. PROJECT BACKGROUND AND DETAILED DESCRIPTION

A. BACKGROUND

Policy Basis

AID's strategy in Burma in the near term is to target modest dollar and local currency resources to increase the access of the rural poor to goods and services required to meet basic human needs. This project was designed to expand and improve Burma's own model effort to develop primary health care workers at the village level. Burmese priorities and programs in this area have already been established, and implementation is underway. The Burmese program is in complete congruence with AID policies and development objectives, including the basic human needs approach.

The Government of the Socialist Republic of the Union of Burma (GSRUB) has shown a continuing commitment to expansion of social services. This is rooted in political concern for equitable distribution of available resources. The Constitution promulgated in 1974 by the Burma Socialist Programme Party states that every citizen has the right to medical treatment for illness. The health programs described below are the major means being pursued by the GSRUB to make this right a reality for the rural majority of Burmese citizens.

Administrative Setting

The country is divided politically into seven Divisions, including all the central plains areas and 70% of the population; and seven States, representing seven ethnic minority areas. These areas are comprised of a total of 314 Townships (27 urban and 287 rural), 13,756 Village Tracts, and 65,320 Villages. Since 1974, Village Tract People's Councils have been established as the most basic unit of local administrative, developmental, and judicial authority. These councils, operating under the policy guidelines of the Burma Socialist Programme Party, are specifically charged with effecting development policies, and provide potential for greatly increasing local participation in implementation and decision-making.

Health Setting

The spectrum of health problems afflicting Burma's population of roughly 32 million is not unlike those of neighboring countries with low per capita income, a tropical environment, poor sanitation facilities and a predominantly agricultural economy. Burma has

several advantages, however, which mitigate the effects of these conditions. Her high literacy rate and the attempts of the government to provide social services to the rural populace have yielded a much greater density of health and educational facilities and manpower than in some neighboring countries. Furthermore, Burma's agricultural production has been sufficient to ward off the widespread malnutrition which is a recurrent feature of the health scene in some other Asian countries.

Available data on health indicators, drawn as they are from selected hospitals and townships, are generally agreed to be not completely representative of conditions in rural Burma. In the absence of better information, some of the published figures are shown in Table One. It seems likely, however, that infant mortality rates -- a useful general indicator of health status -- are in excess of 100/1000 live births, at least in the rural areas. This presumed but unconfirmed level would be in excess of that in Thailand or Sri Lanka, but lower than in India or Bangladesh. Additional information on major causes of hospital morbidity and mortality is presented in Annex C.

TABLE ONE
SELECTED HEALTH INDICATORS

Crude Death Rate	11 per 1000 (1976)
Infant Mortality Rate	56 per 1000 (1976)
Age 1 - 4 years Mortality Rate	11 per 1000
Proportion of Deaths in Children below 5 years	25% (1977)
Maternal Mortality Rate	1.7 per 1000 (1976)
Life Expectancy at Birth	Female: 60 years (1976) Male: 56 years (1976)
Crude Birth Rate	32 per 1000 (1976)
Total Fertility Rate	5.5 (1975)
Population Growth Rate	2.2% per year (1976)
Access to Safe Water	Rural 14% (1978) Urban 31% (1978)
Access to Adequate Sanitation	12% (1978)
Undernutrition in Children Below 5 years	50%
Low Birthweight infants	22% (1978)

Health Services

Burma has had for many years a growing network of modern health services. Physician-based services were supplemented by training of para-professionals such as health assistants nearly 30 years ago.

The existing network of health facilities includes referral and general hospitals at national and Division/State levels offering services of medical specialists. At township levels, there are township hospitals staffed by general medical officers. Towns and cities are served by urban health centers and maternal and child health centers, while rural basic health services are provided by Rural Health Centers (RHCs) and RHC subcenters staffed by paraprofessionals and Station Hospitals manned by medical officers. The number and staffing of these facilities is shown in Annex C.

Township level health personnel include a Township Medical Officer, (TMO) primarily responsible for all health matters of the Township, and a Township Health Officer responsible for the supervision of the MCH Centers, Rural Health Centers, school health and other preventive activities throughout the Township. Except for hospital and nursing staff there is little additional staff at township level, and motor vehicles for field travel are generally not available.

The fourteen Division/State health offices are much better staffed. In addition to hospital staff, a variety of public health personnel are present for support of Township Hospitals, Rural Health Centers and special programs. One or more vehicles are usually available to the Division/State Health Director and his staff.

In addition, a number of specialized and generally vertical public health programs have been developed. These include vector-borne disease control (malaria, dengue hemorrhagic fever, filariasis and Japanese B encephalitis), leprosy, tuberculosis, venereal disease and trachoma control programs, environmental sanitation programs and the newly developed expanded programme for immunization. Due to GSRUB policy, family planning services are not offered (and perhaps not surprisingly one third of hospitalizations related to pregnancy are for complications of abortion.) Most of these programs are operating throughout the country as necessary, with their own staff separate from those of the curative services, but under the direction of the Health Directors in each Division or State.

Burma has an internal capability for production of needed health manpower. In addition to para-professional training programs, Burma has three medical schools, and offers postgraduate training in the major medical specialties including preventive medicine. Training of health assistants was discontinued in 1973, with the intention that HAs would gradually be replaced by physicians in some strategic health centers. We understand that PHS Grade 1's will be given a condensed course of one year's duration and will be deployed as HAs in the rural areas. Further information regarding health manpower is presented in Annex C.

Of the 6100 doctors in Burma, well over half are working in the private sector, primarily because of a dearth of available positions in government service. The same is true to a lesser extent for nurses and midwives. Burma's western-style practitioners co-exist with a large number of traditional healers. Indigenous practitioners are discussed more fully in the social analysis.

B. PEOPLE'S HEALTH PROGRAMME - BURMA'S PRIMARY HEALTH CARE PROGRAM

Within the past five years, two key events have provided the basis for significant reorientation of health services development. The first was the promulgation of the 1974 Constitution and the subsequent health policy guidelines laid down by the Burma Socialist Programme Party. These included, inter alia, added priority to preventive measures, narrowing of the rural-urban differential in health services' availability, and increased public cooperation in improvement of health facilities, in addition to continued expansion of curative services.

The second event was the Country Health Programming exercise carried out in 1976 with WHO assistance. This resulted in the development of the People's Health Programme in Burma for 1977-1982, overlapping the period of Burma's Third Four Year Plan. Six major programs and six support projects were identified (Annex C).

The highest priority within the People's Health Programme was given to the Primary Health Care and Basic Health Services Program, which currently includes:

1. encouragement of communities to recognize their health needs and to undertake health improvement activities;
2. eventual training of 5,240 community health workers to deal with common health problems and organize community improvement projects;
3. training of basic health and special disease control staff to function as multipurpose health workers.

The second priority was given to the Family Health Programme, which includes:

1. strengthening of antenatal, postnatal and child care services, including school health programs;
2. training of 3,200 auxiliary midwives over a period of five years.

Implementation of these two programs was begun in 1978. They form the health services core which this project is designed to augment.

The administrative structure to implement the People's Health Programme is described more fully in the Administrative Arrangements discussion, Part IV. The PHP is being implemented on a township by township basis. At present 70 townships of the 1982 target of 147 have been included, and 616 AMWs and 1459 CHWs have been trained, supplied and returned to their villages. The GSRUB targets for expansion during the current plan period appear in Annex C.

The activities which the AMW and CHW are trained to undertake are presented in Annex C, Tables 9 and 10. Currently AMWs are primarily providing antenatal and delivery services but they have no consistent access to even the most basic drugs such as iron tablets. Although trained in nutritional surveillance and nutrition education, they are not provided with materials for arm circumference measurement or weighing of young children, or for management of diarrhea. However, they appear to be well accepted for delivery services, for which they usually receive some payment. They reportedly often work together with traditional birth attendants - let-thes - in their area.

Most AMWs are young women, and all must be aged 18-45 and meet requirements for literacy and primary education to be considered for selection by their Village Tract People's Council (VPC). Training is six months in duration with the first three months conducted at the township or divisional level and the second more practical half conducted by the LHV and midwives at the Rural Health Center and its subcenters.

CHWs, although trained for a broad spectrum of preventive and curative tasks, appear in practice to be occupied mainly with treatment of common illnesses. They are given an initial supply of 11 drugs, including oral rehydration salts for diarrhea, sulfonamides, antibiotic ointment, aspirin and vitamins, but excluding chloroquine. Replenishment of this supply, planned to last six months, is intended to be paid for by the community. Needed improvements to the resupply system (which is discussed in detail in the Technical Analysis) are under active consideration by the DOH. CHW activities in latrine building, well chlorination and health education are reported, but little stress is placed on preventive health activities by CHWs. No nutritional surveillance of young children is being carried out by CHWs and initial supplies of oral rehydration salts once dispensed have apparently not been available for resupply.

The selection of CHWs, as for AMWs, is done by the VPC, following DOH criteria of local residence, literacy, age between 18 and 60, and willingness to serve the community free of charge for three years after training. Although most CHWs are male, some women have been chosen; they are usually young people. Training for CHWs is

presently of 21 days duration, conducted usually at the township level. Most training has been done by lecture method, with little opportunity for practical experience. Considering the very broad job description, it has been questioned whether this is an adequate duration for initial training. Until very recently, there have been no inservice training programs to supplement initial training for either CHWs or AMWs.

Job descriptions and training programs for AMWs and CHWs have been developed semi-independently by staff of the two separate PHP programs concerned. Given a striking shortage of central staff in both projects, similar methods were used based upon a heavy reliance on workers at Division and Township levels for training and supervision. Once curricula and training materials were designed and approved, a series of training-of-trainers courses was conducted centrally for Division/State personnel, at Division/State level for Township personnel and at Township level for the Station Hospital and RHC personnel, who, with Township staff, would be responsible for actual training of CHWs or AMWs. In all cases this training has been done by Divisional and Township health workers in addition to their normal responsibilities. Teaching materials have been minimal, although manuals for both workers have been printed within the past year.

Supervision of PHC workers is mainly the responsibility of RHC staff. In the areas visited, supervision at this level appeared good with most workers reporting 1 - 2 visits monthly to their village by RHC personnel. Supervision from the Township and Divisional level is limited by shortages of both personnel and transport.

Referral services are available at RHCs and Station Hospitals. The latter in general are only marginally better equipped than RHCs, although they are the lowest level in the system staffed by a doctor. Intravenous rehydration for severe diarrhea is at present not available at RHCs. The frequency with which CHWs refer villagers to RHCs appears to be low.

Monitoring and evaluation of the various People's Health Programme activities has been given serious attention by the DOH. These activities have centered in the priority Health Information System support project. A complex routine monitoring system has been developed and tested in some townships. It is anticipated that this system will be revised on the basis of experience and perhaps simplified. Impact evaluation will also be undertaken by this project and the Health Practice Research Support Project. A proposal for monitoring infant and childhood mortality

using data gathered by midwives throughout the PHP areas is in the early stages of implementation, as well as plans for monitoring other indicators such as birth weight, height of school entrants and tetanus neonatorum death rates.

The implementation of the primary health care worker programs described above represents a major step by the GSRUB towards increasing access of the rural majority to modern medical care and raising the health standards of Burma's villagers. It also represents an important model of low-cost, auto-financed health care delivery by village volunteers which is of great interest to health workers within Burma and around the world. At this stage it must be viewed as a rather daring experiment with putting current theory into practice on a national scale. At present it appears to be working reasonably well, but both local and outside observers are aware that only a continuing effort to evaluate and modify as necessary the various components of the project will result in an effective, optimal approach.

C. DETAILED PROJECT DESCRIPTION

Introduction

Based upon their experience to date, the GSRUB in June 1979 identified several areas within the People's Health Programme which merited more rapid expansion and support than had been planned and budgeted for during the current plan period. Of these, AID was requested to support a substantial expansion of CHW training and strengthening of nutrition and diarrheal disease control activities. Based upon this request and further discussions with DOH and other GSRUB officials, this project was developed. The project is outlined in the Logical Framework (Annex B) and the description below is based upon that outline. This description focuses on proposed activities. Major assumptions underlying achievement of output targets, as well as project purpose, are discussed in the technical, financial, economic and social analyses which follow.

Sector Goal

"To reduce mortality and morbidity among Burma's rural population, and particularly among infants and young children."

The various components of Burma's primary health care system were selected to make a measurable impact on the more common remediable causes of morbidity and mortality. The strategy of training a large number of unpaid voluntary health workers to provide treatment for common killers such as diarrhea, malaria and pneumonia is thought to be potentially one of the most cost effective approaches to improved health for countries with high levels of readily preventable disease. When preventive activities against malnutrition and diseases associated with poor sanitation are added, the potential impact is further increased.

Evaluation of impact has been built into Burma's system, and should be strengthened by this project. Although significant changes in the indicators selected will not be apparent during the two year span of this project, monitoring during this period will permit more adequate evaluation at a later date.

Project Purpose

"To expand the coverage and the quality of Burma's primary health care system in 147 of 283 rural townships."

The People's Health Plan targets for training of primary health care workers during the Third Four Year Plan will provide a midwife or AMW for 82% of village tracts and a midwife or CHW for 24% of

villages in the PHP townships. This project will increase AMW coverage from 82% to 100% of village tracts and CHW coverage from 24% to 46% of villages in the project area (so that by the end of this project, 55% of the villages will be covered, see Annex D, p.2).

Although assessment of the "quality" of a health care system is fraught with hazard, substantial effort in the design of AID's contribution has gone into identifying activities which can improve specific parts of the system. One such type of activity is the addition or strengthening of high impact services such as rehydration therapy for diarrheal disease, nutrition surveillance and intervention in young children, malaria treatment and prophylaxis and iron supplementation during pregnancy. A second type is the strengthening of health system processes of training, supervision, referral and evaluation, which should increase the quality of the health care system at several levels.

Project Outputs

"1. An increased number of trained primary health care workers supplied with necessary drugs and equipment and providing an expanded range of services."

This project will support the training and equipping of 1400 AMWs and 7,418 CHWs in addition to the number previously planned by the GSRUB (Annex D.) The quantity was determined on the basis of training capacity. Additional training of AMWs will continue a second and third year in each township until an AMW has been trained for each village tract. CHW training will shift to the RHC, and will be conducted mainly by RHC staff. A maximum of 10 CHWs will be trained by each RHC per year to minimize disruption of other RHC activities including supervision and in-service training of PHC workers already trained.

Basic drug kits for AMWs and resupply of oral rehydration salts and chloroquine for both CHWs and AMWs will be provided to all primary health care workers including those trained under the original PHP plan.

Although let-thes are expected to assist in a decreasing proportion of births in future years, they will continue to play a major role in provision of delivery services in rural areas for some time. This project therefore includes support for the training of 1000 let-thes to provide safer delivery services. This training, already carried out on a pilot basis in five RHC's in two townships, will be expanded into two Divisions. Training will be of 30 days duration, with an

initial 3-5 days period followed by one day weekly for the next six months. Since training is conducted in the let-thes' villages by the midwives as part of their normal work, project support is needed only for training the midwives as let-the trainers, and for supplying the let-thes.

In-service training will be required by all PHC workers trained prior to the start of this project to upgrade their skills in oral rehydration therapy, nutritional surveillance and other expanded activities. Because regular in-service training is even more critical for minimally trained workers than for more professional levels, such training should be institutionalized. Therefore support will be provided for training of all active AHWs and CHWs for an average of one day each month at all project RHCs. (Annex D.)

In order to provide local leaders with a clearer understanding of the People's Health Plan, criteria for selection of AMWs and CHWs, and the role of these workers, the project includes one day orientation programs for VPC members in all village tracts where AMWs or CHWs are selected to undergo training. VPC members will also receive training in the use of oral rehydration therapy in villages where there is no AMW or CHW, although no AID support for this activity is required.

"2. Increased capability of health services to design and implement effective training and supervision programs."

The central level projects responsible for the AMW and CHW programs are at present seriously understaffed. At the Division/State level, where much of the implementation responsibilities lie, there are no staff who are exclusively responsible for primary health care activities. Therefore as part of this project 28 doctors and 12 public health nurses will be added to Division/State Health Directorates as Division/State Training Teams.

These people will be trained and equipped to provide improved training and supervision of primary health care activities. They will work in their own Division/States for part of the year conducting training-of-trainers programs and supervising township, RHC and PHC workers. They will be responsible with other Division/State and township health workers for training 2,335 RHC staff as trainers of CHWs in order to expand the training capability to meet project targets.

For several months each year, Division/State Training Teams will gather together to evaluate their activities and plan for the future. Major attention will be on review and revision of AMW

and CHW job descriptions and various training curricula, development of training materials for use at all levels, and guidelines and other supporting tools for supervisors. Recommendations for change in duration of training (such as increase in the length of CHW training) or content of training can be developed by these teams, and, if approved, appropriate changes can be made in the course of this project.

These teams will also prepare training modules for RHCs to use for in-service training of PHC workers. During the first year of the project these will include nutritional surveillance and intervention, oral rehydration therapy and use of chloroquine for treatment and prophylaxis.

"3. Improved and expanded referral and supporting services available at better equipped RHCs and station hospitals."

As AMWs and CHWs are able to meet an increasing portion of the primary health care needs of their village areas, the referral and supporting role of the basic health services such as RHCs and station hospitals becomes more important. Included in this project is support for in-service training of BHS workers to increase their capability for support.

With the attention given to oral rehydration therapy for diarrhea by CHWs and AMWs, it is important that referral services be available for intravenous rehydration of the small proportion of individuals with severe diarrhea who cannot be treated with oral fluids alone. Therefore intravenous fluids and equipment are being made available to station hospitals and RHCs ~~(A)~~ and training where there is a medical officer, in intravenous techniques will be included in in-service training programs.

The most peripheral health unit staffed by a doctor is generally the station hospital. However, with the limited supplies and equipment generally available at station hospitals, their capabilities are often little more than that of a health assistant at an RHC. Therefore 60 station hospitals will be provided with additional supplies and equipment necessary for expanding their referral capabilities.

"4. Increased capability of health services to monitor and evaluate impact of the primary health care and basic health service program."

Plans for evaluation of both administrative and service achievements and program impact are being implemented. However, present evaluation plans seem unlikely to yield valid information regarding the health effects of adding a large network of primary health care workers to the existing basic health service structure. This project

will support attempts to develop a feasible approach to such an evaluation using indicators already selected by the DOH. It will also support implementation of such a plan as well as other relevant monitoring and evaluation studies.

Since present staff are unable to effectively process and feed back monitoring information on time, 20 additional health information staff for central and Division/State levels will be supported by the project, trained and equipped. In addition, supplies and equipment necessary to support the expanded demands on the new computer being provided to the Health Information System, DOH, by WHO will be provided by this project.

Project Inputs

Details of inputs are provided in the Financial Analysis and Plans (Section III.C), Logical Framework (Annex B) and the Detailed Budget and Financial Data (Annex E). The bases for selection of the proposed inputs are discussed where appropriate in the Project Analyses (Section III).

The short term technical assistance is directed at assisting in defining the most appropriate nutrition interventions for AMWs and CHWs, improving training, curriculum development and materials development skills of central and Division/State training teams, improving monitoring and evaluation activities and strengthening the commodity management capabilities of the DOH to accommodate AID's additional inputs.

The participant training programs offered are intended to support longer-term staff development within the DOH. Although they are in areas of direct relevance to this project (Maternal and Child Health, Nutrition, Health Education, Health Services Management, Training of Trainers and Primary Health Care) the major benefit of this training will be accrued only in the years following the project.

The commodity, in-country training and local salary and support costs are all supporting achievement of the various project outputs.

In addition to contributions from GSRUB and local communities, WHO and UNICEF are major contributors to the overall primary health care program. WHO has been assisted the GSRUB by financing advisory services and participant training, while UNICEF has provided some advisory services in addition to all imported drugs and equipment for initial voluntary worker supplies. This project has been developed in close collaboration with these agencies and AID's contributions are complementary to and do not duplicate those of any other donor.

III. PROJECT ANALYSES

A. METHODOLOGY OF ANALYSIS

The project paper team used the following major sources of information in preparing the analyses:

1. Existing documents, reports, books, and articles regarding Burma's health system.
2. Extensive interviews with individuals knowledgeable about contemporary health and socio-economic conditions in Burma, especially Burmese with a great deal of rural field experience and expatriates working for international donor agencies.
3. Field visits to observe AMW and let-the training, Rural Health Centers, Township and Station Hospitals, CHWs and AMWs at work in their respective villages, and the activities of Village People's Councils.
4. In-depth discussions with a large number of Burmese officials, primarily those working in the MOH but also including officials of other ministries and agencies.

After collecting as much data as could be obtained, the team attempted to synthesize these data into brief but coherent analyses. This was done on the basis of the following assumptions:

1. Any AID-assisted project would not be entering a health vacuum; the Burmese have developed rural health services over the past half-century. Therefore, any AID contributions would be a small part of a complex historical process.
2. The experiences of other developing countries trying to implement national primary health care programs should be kept in mind, especially the gap between stated goals and actual performance. At the same time, it was clear to the team that the Burmese have met most of their PHC targets so far.

B. TECHNICAL FEASIBILITY

Primary Health Care Strategy

As is apparent from the quotation from J.R. Andrus at the beginning of this Project Paper, a primary health care system similar to that of this project had been developed in Burma long before the recent reinvention of primary health care. Although little trace of that system survived the ravages of World War II and the subsequent socio-economic and political changes in Burma, the approach had resurfaced and moved into implementation well in advance of the stimulation of WHO's 1978 Alma Ata Declaration on Primary Health Care. This is at the least indicative of the depth of commitment of the GSRUB and its health officials to this strategy for the provision of more and better health services to its largely rural population. This commitment, coupled with the existing rural health service infrastructure, make it possible for the Burmese to greatly expand the coverage of their primary health care system in a relatively short period of time.

This strategy is technically feasible for several reasons. The level of technology involved (oral rehydration therapy, curative treatment for pneumonia, anemia, and worms, nutrition surveillance using growth charts and arm circumference bands) is appropriate for use by workers with limited training in rural Burma. The emphasis is on interventions which are safe and likely to be effective in reducing the adverse effects of common conditions. Furthermore, as indicated in the Economic and Social Analyses (Sections III.C and III.D), this strategy is low cost for both the GSRUB and the villagers, and is congruent with local social characteristics.

Preventive Orientation of Primary Health Care Workers

CHWs presently working in Burmese villages are now mostly concerned with curative rather than preventive care. This is due to strong villager demand for curative drugs and relative indifference towards health education and preventive measures. Burmese project administrators will have to experiment with different forms of incentives aimed at shifting this balance. Methods for improving village-level supervision are likely to help. Ultimately more informed villagers who understand the importance of prevention will change the structure of demand. Although curative biases are less obvious for AMWs who presently have no drugs to dispense, they too appear to be less active in preventive care than they might be. When they are provided with drugs (for preventive and curative care), as they should be, more attention may also need to be given to their maintaining an appropriate balance between preventive and curative services. This can best be worked out in the course of implementation.

Referral Services

The improvement of referral services at RHCs and Station Hospitals is an important component of this project. However, although referral is an important and useful component for the small proportion of ill persons who need it, it is rarely achieved in practice. Because of the widespread distribution of RHCs, the time and cost of referral to that level may be acceptable to many villagers. It is likely that by increasing the range of services provided, the perceived value of referral services to villagers will be increased sufficiently to increase appropriate utilization.

Primary Health Care System Coordination

The training of the two key types of PHC workers -- CHWs and AMWs -- has thus far been developed by two distinct, quasi-autonomous projects at the central level. Although DOH officials have offered repeated assurance that central coordination has not been a problem to date, it is obvious that a high degree of coordination of planning and implementation at all levels will become increasingly necessary if maximum effectiveness is to be achieved as the program expands more rapidly. The limited number of central staff also is a deterrent to coordination because of conflicting demands on limited time.

Coordination at Division/State, township, RHC and village levels does not appear to be a problem, since both programs are managed by regular basic health service staff at those levels.

Because this project supports the expansion of both types of primary health care worker, it is likely that the necessities of project management will increase coordination. For this reason, it is important that the GSRUB counterpart of the USAID project manager be at a level capable of supervising and coordinating both the CHW and AMW programs. The Director of Public Health serves this role and is expected to be named project manager.

Nutrition and MCH Activities

The nutrition activities supported by this project have the potential of significantly affecting mortality in mothers and young children. The provision of scales, growth charts and other supplies for nutrition surveillance and education will increase the potential impact of AMWs. Additional training, after agreement is reached on the best interventions to be taught, plus better supervisory support, should help realize that potential. Furthermore, joint in-service training with CHWs in detection and management of nutritional problems should promote teamwork and cooperation in these activities at the village level.

The provision of a simple drug kit to AMWs will increase their effectiveness as well as increasing their credibility as health care providers. The present six months training period easily allows enough time for developing competence in the use of basic drugs.

Oral Rehydration

The use of oral rehydration salts made widely available by CHWs and AMWs, can by itself significantly reduce diarrheal disease mortality. CHWs presently working in villages have within one year distributed virtually all of the 150 oral rehydration packets that had originally been provided them (and kept individual records on use), thereby demonstrating the feasibility of the CHW as a mechanism for village-level distribution. In order to promote still wider availability, this project will provide sufficient oral rehydration salt packets for initial and resupply of both CHWs and AMWs, who will both receive in-service training in its use.

Both AMWs and CHWs are currently trained in the preparation of home-made salt and sugar solutions for oral rehydration. Plans are underway in the Department of Medical Research to field test the reliability of this method. Although the homemade solutions are less satisfactory than prepared salts, it would be advisable during project implementation to consider whether or not this approach should be stressed in training as an alternative when oral rehydration salt packets are unavailable.

Communicable Disease Control

As the PHP develops, it is intended that PHC workers will assume some of the responsibilities of the special disease control projects. This process appears to be proceeding very slowly at present. It is probably advantageous to sharply limit the number of tasks the PHC workers assume at the beginning. As they gain experience, additional tasks can be added through in-service training and reinforced by field supervision.

However, it appears that critical tasks such as treatment of malaria should be carried out by PHC workers from the start. Therefore this project will provide chloroquine to CHWs in malarious areas for presumptive treatment of malaria, and to AMWs in areas under drug control by the VBDC project for prophylactic treatment of children and pregnant women during the transmission season. Both of these activities will be carried out with the technical advice of the VBDC program. Chloroquine resistant P. falciparum has been well documented in Burma, primarily at the R-1 level. In 1974, the frequency of resistance was 26% among 445 P. falciparum infections

(the predominant species) from widely scattered areas of the country. This degree has not been considered by local malaria staff or WHO advisors to warrant modification of present drug availability or prophylaxis programs.

All PHC workers are intended to assist special disease control project activities when they occur in their own areas. This includes assistance with immunization, trachoma, tuberculosis and leprosy programs. Prioritization and further development of AMW and CHW activities in support of these programs will be an appropriate task for project staff and trainers in the course of implementation.

Environmental Sanitation

Although CHWs are trained in the chlorination of wells and the construction of simple latrines, these activities are not likely to result in a lowering of morbidity or mortality unless a very high proportion of villagers decide to adopt and enforce better hygienic practices. Additional support for sanitation activities is therefore not included in this project because of its lower likelihood of benefit. However, should PHC workers prove more effective in this area during implementation, additional support should be considered for any follow-on project.

Training Strategies

The initial training of AMWs and CHWs supported by AID will occur only in townships in which an initial group of these workers has already been trained. This township staff will already be experienced in conducting such training. Because of the limited numbers of additional AMWs to be trained, their training will be similar to that already being conducted with apparent success.

In order to substantially increase the number of CHWs trained, it has been proposed that their training be conducted by RHC staff rather than at the township level as before. This has the advantages of conducting training in a setting more like that in which CHWs will work, will ensure small classes (a maximum of ten) and facilitate the use of discussions and practical exercises, as well as utilizing the same persons as trainers who will later be supervising these workers. It has the disadvantages that RHC staff are unlikely to have much teaching experience or to understand the program as well as township health staff.

In view of the extensive job description of the CHW, it is unlikely that CHWs can achieve competency in all the specified activities in the brief three weeks of training he receives. Unless the CHWs

tasks are considerably reduced, (and this project is supporting an increase in both tasks and training), serious consideration should be given to the possibility of increasing training duration during the course of project implementation. Should a reasonable increase in duration be recommended by the DOH during the course of this project, it is anticipated that AID Kyat assistance might be adjusted appropriately to support such changes.

Another response to the short initial training is the substantial (12 days per worker per year) in-service training provided by the project for all AMWs and CHWs. Regular refresher training is widely recognized as beneficial to both morale and operational quality. RHC staff conducting in-service training will attend a training-of-trainers course and will also be provided with guidelines and teaching aids for some of these programs.

Training Quality

A critical constraint in the development and implementation of AMW and CHW training programs to date has been the lack of adequate staff at any level. This will become more serious as the program expands. To overcome this problem the project will support and equip training teams in each of the fourteen divisions and states. These teams will each comprise four individuals: two doctors and one public health nurse appointed on a temporary basis for this project, and one health educator already assigned in each Division/State. These teams, working part of the year in their Division/States as trainers of trainers and part of the year together with central staff as a core group for curriculum and materials development, will be primarily responsible for helping township and RHC staff become more effective trainers and supervisors. Such a group, well trained and supplied, should have a very positive effect on the quality of health worker training.

Training Capacity

The initial GSRUB proposals from which this project was developed requested support for training 25,000 additional CHWs during a three year period. Further analysis suggested that this number would be difficult to implement at an acceptable level of training quality. The numbers proposed in this project are based upon tentative training schedules which appear to be achievable without seriously disrupting other health service activities. However, critical to achievement of the proposed targets is the strategy of having CHW training done at the RHC level. It is likely that this will be successful. However, as with any new approach, it should be monitored carefully during implementation so it can be modified if necessary.

Training of AMWs has already been shown to be within GSRUB capacity. The additional numbers to be trained will not exceed that capacity. Let-the training has been successful on a small scale already. It appears likely that this training can be expanded to the proposed level without difficulty. A factor which could have great impact on training requirements is the attrition rates of AMWs and CHWs. Although reportedly low at present, the program is too new to be able to predict how often PHC workers will need to be replaced.

Supervision

Since Burma's primary health care workers are not government employees, regular supportive supervision is the main mechanism by which to influence volunteer workers to work more effectively. It is expected that the Division/State training teams will also be concerned with enhancing the supervisory effectiveness of basic health service staff through better training and more supervision from higher levels. Since present levels of supervision at the RHC level appear adequate, attention can be focused more on methods of supervision.

One area of concern is the number of RHC staff responsible for supervision, particularly the public health supervisor (PHS). The PHSs are special project staff reassigned from township level to RHCs after training. Because of the smaller area covered by a PHS, many of them may lose their travel allowance (which can make up 50% of their total income) upon transfer as a multipurpose RHC worker. The deployment of PHSs in RHCs appears to be lagging behind schedule. CHW supervision may suffer if adequate numbers of staff are not available at RHCs.

Supervision above the RHC level is often inhibited by lack of time and lack of transport. Although considered initially, this project was unable to address the problem of transport requirements in any substantive way because of GSRUB restrictions on supply of vehicles to projects. This will likely continue to be an important constraint to effective supervision, particularly at the township level.

Supply and Logistics

The ability of CHWs and AMWs to improve health status depends upon a continuous supply of drugs. The DOH has a logistic capability for supplying hospitals and RHCs which is sub-optimal but functioning. Limited support to ensure its ability to handle project inputs will be provided.

Because the PHP programs are both new and relatively small, their logistics system for resupply has not been adequately tested. There appears to be widespread agreement that provision of funds by communities for resupply of CHW drugs has not and will not be a major

problem, except in very poor villages.

The DOH previously arranged for a fixed package of locally produced drugs to be sold to CHWs through their local cooperative societies. This worked well for resupply, but had the disadvantages of requiring that the DOH be involved in estimating demand and of being incapable of responding to variations in drug requirements among the items in the kit. Direct sales through the DOH's own logistics system is not possible because of prohibitions on the sale of drugs by the DOH. Alternative solutions to the mechanism of resupply of locally available drugs are being sought by the DOH, including the possibility of providing the drugs through the DOH and making payment through the rural cooperative stores or the GSRUB Trade Corporation stores. The DOH has agreed to focus on this problem and produce a strategy for translating the funds available in the community into resupply commodities.

A more serious problem is the availability of locally produced drugs. The production capabilities of Burma Pharmaceutical Industry (BPI) are inadequate for current needs, and planned expansion is not likely to be operational during the life of this project. If production capacity increases, there may be problems obtaining adequate foreign exchange to purchase necessary raw materials. These problems can be solved in a variety of ways.

Furthermore, oral rehydration salts, an important project input, are not yet available from BPI, although initial production is scheduled for late in 1980. It is partly for these reasons that resupply of oral rehydration salts and antimalarials is included in the project, to be provided free of cost. The project manager is also free to consider whether it would be advisable, in the second year of the project, to substitute raw materials purchased from UNICEF for finished oralyte packets purchased from UNICEF, if this procedure is more cost effective and if it would be helpful in expanding local production capability. In addition, for those villages which are too poor to provide the Kyat for resupply (i.e. where Kyat and not foreign exchange is the key constraint) the forward funded commodities noted in the Financial Analysis and Plans (Section III.C) could be directly rechanneled to the village for resupply without charge.

If demand is generated and the DOH is unable to meet resupply requirements, there are widely available open market sources of drugs which might be utilized by CHWs and other villagers. This market is a relatively expensive but important part of the internal supply system. It is estimated that at least 10 - 30% of all drugs consumed are obtained in the open market.

There appear to be adequate controls to prevent leakage of current UNICEF supplied drugs to the open market. Therefore, although some leakage of AID-supplied commodities is possible, the amounts would probably be very limited, and could be easily monitored by market spot checks. A few instances have been reported of CHWs trading their supplies on the open market. Those instances resulted in strong disciplinary action being taken by the concerned Village Tract People's Council.

Evaluation

Despite the paucity of representative health data for rural Burma, there appears to be considerable interest in evaluation of health programs. A substantial effort was put into the design of monitoring and evaluation systems for the People's Health Plan. On closer examination, however, there are apparent problems of the usual varieties: more data is being collected than can possibly be processed or used, data is funneled to the center rather than being used for management at the periphery, and study designs are inappropriate for the questions they attempt to answer.

Because of the pioneering nature of Burma's primary health care system, it would be particularly useful to have high quality evaluative information on its effectiveness. This project supports improvements in the health information system, including support for design of improved impact evaluation studies. Illustrative of the type of study which might be undertaken is a proposal to monitor over time and compare selected health indicators in areas with and without AMWs and RHC staff in sample areas as data collectors.

Conclusion

This project as designed is technically sound, feasible and appropriate. Issues identified but not resolved are not critical to project design, but are appropriate concerns for project implementation.

C. FINANCIAL ANALYSIS AND PLANS

Project Costs

The total project cost is estimated to be \$16,588,000 (see Table Two). The AID contribution is \$5 million of grant funds for foreign exchange costs and roughly \$1.5 million equivalent of US-owned excess local currency for local costs. Other donors (UNICEF and WHO) are contributing 28% of total project costs, all in foreign exchange.

The Burmese contribution, including community contributions, constitutes 30% of project costs in the first year and 35% in the second year. These percentages are based on very conservative allocations of Department of Health planned expenditures and on similarly conservative estimates of community contributions.

Detailed summaries of the AID dollar and local currency contributions are included in Tables Three and Four. By far the biggest dollar component, 80% of the AID dollar total, is for the purchase and shipment of commodities, most of which will be used directly by the primary health care workers. Some commodities will also be used at the nearest referral point from the village, either an RHC or a Station Hospital. The remainder of the AID dollar contribution is for technical assistance (about 12%), for participant training (3%) and for in-country training and evaluation materials (5%).

The major share (85%) of AID's local currency contribution goes directly to village workers in the form of per diem payments during pre-service (58%) and in-service (23%) training. The remainder is for salaries of D/STT training and supervisory teams (11%) and for Health Information Service of the Department of Health (8%) to expand project evaluation activities.

Primary Health Care Worker Training and Deployment Costs

Unit costs for the deployment of primary health care workers are estimated in Table Five. The estimated \$160 deployment cost per CHW compares favorably with the deployment of similarly trained workers elsewhere; for example, for Village Health Workers in Afghanistan the corresponding unit cost was approximately \$200. Per capita costs of deploying both CHWs and AMWs approximate \$0.30, assuming an average village population of 500, and an average village tract population of 2000.

TABLE TWO
TOTAL PROJECT COST (\$000)*

	YEAR 1		YEAR 2		TOTAL	
	\$	%	\$	%	\$	%
BURMESE CONTRIBUTION	2,014	30	3,446	35	5,460	33
<u>GOVERNMENT</u>	<u>977</u>	<u>14</u>	<u>1,178</u>	<u>12</u>	<u>2,155</u>	<u>13</u>
<u>COMMUNITY</u>	<u>1,037</u>	<u>16</u>	<u>2,268</u>	<u>23</u>	<u>3,305</u>	<u>20</u>
UNICEF	1,688	25	2,056	21	3,744	23
WHO	434	6	491	5	925	5
US AID	2,684	39	3,775	39	6,459	39
<u>\$</u>	<u>2,000</u>	<u>29</u>	<u>3,000</u>	<u>31</u>	<u>5,000</u>	<u>30</u>
<u>LOCAL CURRENCY</u>	<u>684</u>	<u>10</u>	<u>775</u>	<u>8</u>	<u>1,462</u>	<u>9</u>
TOTAL	6,820	100	9,768	100	16,591	100

*Details of calculations may be found in Annex E: Detailed Budget and Financial Data.

TABLE THREE
SUMMARY OF AID DOLLAR CONTRIBUTION (\$000)

	<u>1979-80</u>	<u>1980-81</u>	<u>TOTAL</u>	<u>% OF GRAND TOTAL</u>
1. TECHNICAL ASSISTANCE	124	229	353	7.1
2. PARTICIPANT TRAINING		107	107	2.1
LONG TERM		60	60	1.2
SHORT TERM		47	47	.9
3. COMMODITIES	1,486	1,808	3,294	65.9
HEALTH WORKER KITS	928	930	1,858	37.2
INSTITUTIONAL KITS	146	117	263	5.2
OTHER MEDICAL SUPPLIES (FOR VILLAGERS)	247	688	935	18.7
HEALTH INFORMATION SERVICES	23	2	25	.5
TRAINING MATERIALS FOR TRAINING TEAMS	112	71	183	3.7
AUDIO-VISUAL EQUIPMENT SET FOR CENTER TRAINING	30		30	.6
4. SHIPPING (20% OF COMMODITIES INC. INFLATION)	309	410	719	14.4
5. INFLATION*	81	304	385	7.7
6. CONTINGENCY		142	142	2.8
GRAND TOTAL	2,000	3,000	5,000	100

(* Calculated separately for all major categories. See Annex E for details.)

TABLE FOUR

SUMMARY OF AID LOCAL CURRENCY CONTRIBUTION

	1979-80 KYAT (000)	1980-81 KYAT (000)	TOTAL KYAT (000)
TRAINING OF VILLAGE WORKERS	3,308	4,415	7,723
CHW PRESERVICE	1,071	1,347	2,418
CHW INSERVICE	492	1,079	1,571
AMW PRESERVICE	1,278	1,285	2,563
AMW INSERVICE	220	416	636
VILLAGE COMMITTEE ORIENTATION	247	288	535
TRAINING OF TRAINERS + OTHER INDIRECT VILLAGE SUPPORT	767	256	1,023
HEALTH INFORMATION SERVICE/ EVALUATION SUPPORT	376	376	752
TOTAL IN KYAT (000)	4,451	5,047	9,498
TOTAL IN US \$000 EQUIVALENT (@ K6.51/\$1)	\$ 686	\$ 776	\$1,462

TABLE FIVE
DEPLOYMENT COSTS FOR EACH PRIMARY HEALTH CARE WORKER

	CHWs		AMWs	
	Kyat	%	Kyat	%
Training per diems at K. 10/day	210	20	1,800	46
Trainers Costs (1)	43	4	366	9
Training Support Costs (2)	88	8	540	14
Kits	702	68	1,190	31
Total in Kyat	1,043	100	3,896	100
Total in U.S. Equivalent	\$160/CHW		\$600/AMW	

- (1) When training a class of 10 village workers RHCs are assumed to devote a quarter of their resources (mainly personnel) to the training effort.
- (2) This figure is calculated from the AID \$ and Kyat contributions for training of trainers. This overstates the cost if, as is likely, trainers will train more than one group of trainers. This estimate is derived from Tables in ANNEX E, (Costs of U.S. technical assistance and participant training have not been attributed directly to the cost of deploying PHCs.)

Primary Health Care Worker Recurring Costs

As discussed in the Technical Analysis, (Section III.B) the community bears primary responsibility for funding the resupply of drugs which the village worker can then purchase from either government sources or the "open" market. The main exceptions are oral rehydration salts and chloroquine, both of which are in critically short supply. Therefore, a small portion of AID assistance (9%) will be devoted to assuring an adequate re-supply of these drugs, and to in-service training for CHWs and AMWs. Salary and RHC allocated costs have been calculated in the same way as for the estimation of the Burmese contribution in Table Two. For recurring costs see Table Six.

While the community bears primary responsibility for recurring costs (76%), the GSRUB has responsibility for approximately 23%. This will pose little financial difficulty since the introduction of the PHC workers basically involves a shift in RHC responsibilities to include supervision and continuing education of the workers, and therefore, does not necessitate an expansion of the GSRUB payroll.

The relatively low cost of in-service training is worthy of comment. Although a miniscule portion (approximately 0.2%) of the project budget is devoted to this effort, it is very important as a means of maintaining and upgrading worker skills and improving morale. It is expected that this small expenditure will have a disproportionate impact upon both the quantity and quality of services delivered by the PHC workers.

Evaluation Costs

Costs of evaluation are also a minor element of the budget (only 2% of AID's input), but these expenditures will yield a high rate of return when the data collected is fed into the planning process. Only when this data is assimilated can alternative approaches be adequately evaluated on the basis of relative costs and effectiveness. Therefore, AID's critical input in this area will go a long way towards assuring data availability for the next GSRUB four-year planning exercise and for the planning of potential AID-supported follow-on projects.

Commodities

A major purpose of this project is to enhance the capacity of the GSRUB to carry out its own training plans, including a second phase beginning in FY 82 to extend coverage throughout the rural areas. Accordingly, part (\$1,432,000 or 27%) of AID's contribution under this project consists of funding commodities through FY 82. Purchase and delivery of these commodities, mainly primary health care worker kits and drugs, will permit the GSRUB's program to continue at a slightly increased rate of expansion. Failure to fund these commodities at this time would result in shortages of kits and oral rehydration salts and cause a potentially dangerous loss of momentum. Even without follow-on AID assistance, GSRUB provision of drugs and supplies would be disrupted before sufficient domestic production was on line. It is included in the project from the start in order that the GSRUB has an indication of the extent of continuing support when it begins its four-year planning exercise in mid-1980.

TABLE SIX
ANNUAL RECURRING COSTS FOR EACH PRIMARY HEALTH CARE WORKER

	<u>CHWs</u>		<u>AMWs</u>	
	Kyat	%	Kyat	%
Drugs				
- Community-funded	600	36	300	17
- Oral rehydration salts	84	5	41	2
- Chloroquine (AID-funded)	84		86	5
Honorarium (Labor Contribution)	600	36	900	53
RHC Allocated Costs	275	16	275	16
In-Service Training Per Diem (AID-funded)	<u>120</u>	<u>7</u>	<u>120</u>	<u>7</u>
TOTAL (Kyat)	1685	100	1722	100
TOTAL (U.S.\$ equivalent)	\$260/CHW		\$265/AMW	

Reasonableness/Firmness of Costs

Because of the short duration of the project, calculating inflation rates and allowing for probable increases in the costs of commodities, as well as services and training, did not present a major problem. Estimated rates of inflation were calculated separately for each major category of expenditures based on recent inflation rates. Thus, for example, it was estimated that inflation in the costs of commodities and shipping would be more substantial than that associated with providing short-term technical advisory services. Detailed cost projections, Annex E, include estimates of inflation for all foreign exchange costs over the two-year life-of-project. In view of the fact that Burma has actually experienced deflation in recent years, inflation in local costs is not anticipated and was not budgeted.

Conclusion

The unit costs are reasonable and compare favorably with similar projects elsewhere. No difficulties, on the part of the GSRUB, are anticipated with financing the project since the AID input is accelerating and expanding activities already planned and budgeted. GSRUB budgeted amounts would not be sufficient, however, to cover the costs of customs or taxes in the event they were levied against the imported commodities. To preclude the possibility that this could occur and seriously impede project implementation, a condition precedent is recommended which requires evidence that adequate funds have been budgeted by the GSRUB to cover such costs or that a waiver has been granted exempting project commodities from any such charges. Finally, the design of the PHC system around community contributions reduces the financial burden on the GSRUB of maintaining the system once AID and other donor involvement in system start-up have terminated.

D. SOCIAL ANALYSIS

Feasibility of Expanding Modern Health Care in Rural Burma

A number of factors of Burmese culture and the Burmese personality affect both the provision and utilization of health care. These include societal values, Buddhism, the colonial experience and current socialist doctrine, and a personality trait called Anade. The major characteristics of Anade include self-restraint, fear of giving offense or causing loss of face, avoidance of aggression, respect and consideration of others, and gratitude.

The utilization as well as provision of health care are also affected by Buddhism, the dominant religion of Burma. Burmese Buddhists believe that one's present state of health and well-being are the result of one's earlier deeds. Health in this context includes physical, mental and emotional states of being, as well as spiritual health. This view of health status is coupled with the Buddhist concept that suffering is an inescapable and essential element of life; that there are no acts which are not painful. This sense of the inescapability of disease and pain does not, however, deter the Burmese from seeking treatment to alleviate pain and other symptoms of disease.

Individual illness is also tied to spiritualism. A number of supernatural agents of disease are recognized including witches, ghosts, and spirits known as nats. Witches and ghosts are believed to cause a number of diseases such as fevers and gastro-intestinal infections, while nats effect both good and evil in people and are often considered responsible for mental illness.

The provision of health care is considered a meritorious act. In a strongly Buddhist culture such as this one, an important element of compensation consists of merit earned in voluntarily providing a service to one's community. However, as has been noted, voluntarism in the Burmese context means independence from government pay-rolls rather than the absence of any remuneration. Thus, Village Tract People's Councils (VPCs) have been instructed that they may, if they so wish, provide financial compensation. Although evidence is somewhat sketchy, it appears that most AMWs and about half of all CHWs receive some cash or in-kind payment for their service.

In numerous instances, however, CHWs are continuing to work in their roles a year or more after initial training, despite the fact they receive no financial remuneration. Finally, incentives for voluntary service are supplied by current socialist doctrine and a political structure which includes division, township and village tract people's councils at the periphery.

Practitioners of medicine in Burma encompass a variety of therapists ranging from licensed and non-licensed Ayurvedic practitioners through herbalists (hsei Hsaya) and birth attendants (let-thes) to faith healers who recite incantations. A recent GSRUB assessment of traditional practitioners estimated 25,000 (at least one-third of whom are women), or an average of one healer for every two villages. Under a GSRUB licensing policy intended to upgrade and standardize traditional practice, 7,000 healers who work in government dispensaries or are in private practice were registered. The unlicensed 18,000 or so practice as an avocation for which they may or may not receive remuneration. Medicines used by indigenous practitioners are herbal and mineral preparations, most of which are grown or collected and prepared at home.

When illness occurs, the Burmese choose from among available indigenous and western practitioners. Even if rural Burmese know they are suffering from naturally-caused illnesses, they frequently do not consult western style practitioners, no doubt at least in part due to their scarcity in rural areas. For mild disorders and in areas without modern medical facilities, the traditional practitioner is the only source of health care.

In any case, utilization of services is focused on curative care. A complex body of traditional knowledge about the causes of ill health coupled with Buddhist belief in the inevitability of illness and pain result in modern health prevention and health promotion messages not always receiving full attention. On the other hand, demand for medicines, both traditional and western, is high.

Social Soundness of Project

While Burmese villagers often seek care from a nearby herbalist, let-the, or exorcist before consulting a western trained physician or health worker, there is no antipathy toward western-based medicine. The most potent determinant of utilization appears to be availability. Therefore, the expansion of a rural health infrastructure which integrates western medicine into Burmese society is essential to increasing utilization of western-based curative, as well as preventive and promotive health services.

Voluntary health workers will extend services to the village level.

The project strategy of expanding the availability of medical services through increasing the quantity of CHWs and AMWs and improving the quality of care they offer through regular in-service training will expand and upgrade rural health services. Promotion of these workers' activities and their recruitment by the Village People's Councils (VPCs) will enhance their credibility. Further, the policy of recruitment of traditional healers, when qualified, as CHWs will help integrate western-based and indigenous medicine. Although let-thes can theoretically be chosen as AMWs, it is considered unlikely that more than a few will qualify due to their older ages and illiteracy. The AMWs will, however, be encouraged to upgrade the skills of let-thes with whom they work. Further, the GUB plans to expand an on-going pilot project to provide let-thes with upgraded skills, but will do so at a moderate pace over the next two years due to difficulties of identifying candidates who are eligible and desirous of training.

An additional project strategy of relieving drug and equipment scarcity at the village level will increase the credibility of the health workers and should afford them opportunities to offer preventive and promotive health services in conjunction with curative services.

The recruitment of women as AMWs and as a small portion of CHWs is consistent with the generally high status of women in Burma. Burmese women are equal to men under all aspects of the law, although tradition requires them to defer to the "superiority" of the male. Despite this the female is dominant in the household. Women apparently control the family economy and most of the retail trade throughout the country as well. Females today account for nearly half the students in Burma, although the female literacy rate is only 60%, compared to 80% for males.

Women are accepted into all sectors of the economy including education, law, commerce, engineering and the sciences, as well as medicine. Traditionally, however, women doctors concentrated on obstetrics, gynecology and pediatrics. Today, women account for half of all medical students, and female doctors are no longer limited to their traditional patients.

Project Impact

It is obvious that this project will have a direct and positive impact on the health status of Burma's rural population. In addition, some of the consequences of Burma's current high morbidity rates, for instance time lost from work and financial drain on family income caused by medical expenses, will be ameliorated even if the project is only moderately successful in reducing morbidity and mortality rates in rural Burma.

The direct beneficiaries of curative, as well as preventive and promotive, health services include the village-based residents of the 147 townships which will be provided with the improved services of CHWs and AMWs. Furthermore, the project gives emphasis to women and children as beneficiaries. The project's strong emphasis on maternal and child health through nutrition and oral rehydration will result in special benefits to these groups.

The project will also have an impact on women by offering them increased opportunities to serve as providers of health care. All 1400 AMWs and some (probably small) portion of the 7,418 CHWs will be women. While they will be voluntary health workers, as has been shown elsewhere, most, if not all, will receive some financial or in-kind remuneration which will supplement family income.

In addition, the project can be expected to have demographic consequences in both the short and longer-term. These consequences will be felt in terms of both fertility and mortality.

The project anticipates direct consequences for mortality in the short-run through its explicit goal of reducing infant and childhood mortality. While efforts to decrease the mortality rate, especially among children age 0-4, may have the short-run effect of slightly elevated population growth, the longer-term effect should be a decline in the fertility rate.

This is due to a tendency for parents who experience significant changes in the probability of child survival to alter their fertility behavior accordingly, although this shift generally occurs several years after the objective situation has changed. How quickly this

fertility decline will occur is a function of both the speed at which the mortality decline occurs and the pace at which parental perceptions regarding infant and childhood mortality change.

Conclusion

The social analysis of the project suggests that it is socially feasible and that it will directly benefit Burma's rural population. Proposed strategies are socially sound and will be effective in helping to expand the availability of western-based medicine that is integrated into Burmese society and complements an indigenous health system already operating throughout rural Burma.

Some important social issues were not fully resolvable during project design. These include: the nature of the incentive system currently operating among voluntary health workers; ethnic and geographic variability in community support capability and volunteer motivations; duration of volunteer motivation and consequent re-training needs; and, the acceptability/effectiveness of the CHW role as community change agent vs. curative care provider. Such issues will of necessity be more fully explored over the course of project implementation.

E. ECONOMIC ANALYSIS

The primary justification for this project is not an economic one, but one of basic human needs. Access to primary health care is recognized by most governments, including Burma, as a fundamental right of their citizens. Of necessity, an increasing number of these governments, encouraged by WHO's goal of "health for all by the year 2000," are assuming more responsibility for the development of primary health care systems. Burma is one of the few that has any prospect of translating the slogan into reality. This optimistic view is based on the sound economic design of Burma's planned primary health care system, as well as its technical and social feasibility.

Primary Health Care System Cost Analysis

Primary Health Care worker training and deployment costs were discussed in the Financial Analysis. As was noted, these costs are low compared to costs of deploying similar workers in other countries. Further, the GSRUB's recent record in attracting and using foreign assistance for health programs is so good (see Table Seven below) that it seems probable that nearly all the initial training and deployment costs for the entire national system will be met by foreign assistance.

Burma's PHC system has been designed in such a way that over 70% of recurring costs are met by the populations being served (see Table Six in Section III.C). Furthermore, just over half of the remaining cost is being met through a re-definition of the functions of personnel at the sub-center RHC and station hospital levels. This supporting infrastructure is already in place, and its personnel are now being asked to train, supervise, and support PHC workers who perform many of the outreach activities previously assigned to, but not satisfactorily accomplished by, them.

The GSRUB is thus left with a need to raise funding for only 14% of the PHC workers' recurrent costs, or about \$36 per worker per annum. At the rate of increase of 5,000 new workers per year, this amounts to \$180,000 per year or just under 1% of GSRUB current expenditures for preventive health services. This rate of increase should pose little problem to the GSRUB.

TABLE SEVEN (1)
HEALTH EXPENDITURES (\$ x 1,000,000)

	1974-75	1975-76 ⁽³⁾	1976-77	1977-78	1978-79	1979-80 ⁽²⁾
	AMT.	AMT. %	AMT. %	AMT. %	AMT. %	AMT. %
1. Total National Government Expenditure	338	374 11	460 23	535 16	616 15	630 2
2. Total MOH Expenditure (4)	29	30 2	33 10	35 8	40 12	43 9
3. % of Line 1	8.6	7.9	7.1	6.6	6.4	6.9
4. Preventive Exp. (5)	12	12 3	13 7	16 16	17 8	22 31
5. % of Line 2	41.8	42.0	41.0	43.9	42.2	50.7
6. Curative Exp. (5)	14	14 2	15 9	16 3	18 14	16 9 ⁽⁷⁾
7. % of Line 2	47.6	47.7	47.3	44.8	45.3	37.9
8. Other Exp (5)	3	3 0	4 25	4 4	5 23	5 0
9. % of Line 2	10.6	10.4	11.8	11.3	12.4	11.3
10. Foreign Assistance for Health	-0-	-0-	-0-	6	9 69	11 21
11. % of Line 2			0.5	15.7	23.6	26.2
12. Total Private Health Exp. (6)	72	86 19	102 19	109 7	110 1	115 5
% of Line 2	249	290	313	310	278	266 .
(Est. Per cap. Rural Exp. (6)	2.17	2.50	2.92	3.06	3.03	3.09)

- Notes: (1) These figures are converted from Kyats at 6.51 Kyat = \$1.00. The percentages were calculated from the Kyat figures.
(2) Estimated (i.e. budgeted, which in Burma closely corresponds to expenditure).
(3) Percent increase (decrease) from previous year.
(4) This figure includes both recurrent and capital expenditures. Foreign aid has been deducted.
(5) The dividing line between preventive and curative expenditures is an artificial one. This breakdown is derived from a more detailed one provided by the Department of Health's budget and finance office. Preventive expenditures include all programs in rural areas below the Township hospital, including the vertical programs, the biggest of which is the malaria campaign. All hospitals, except the small station hospitals, are considered "curative". All preservice training is included in "other".
(6) Estimates, based on survey data, provided by the budget and finance office of the Department of Health.
(7) To conserve resources hospitals stopped providing free meals to all but the poorest patients.

The community contribution of 1200 Kyat (\$185) per PHC worker per year (see Table Six in Section III.C) seems affordable. For the CHW, with a catchment area population of approximately 450, the total annual per capita cost is 2.7 Kyats, while that for the AMW is only 6 Kyats. The total annual recurring cost burden on the community for primary health care is 3.3 Kyats (\$0.50) per capita, or approximately one sixth the estimated current per capita health expenditure (\$3.09/year) in rural Burma. The convenience of having a trained PHC worker with a useful armamentarium of drugs and supplies should be an attractive alternative to many villagers.

The health services provided by the PHC system should be considerably more cost effective than those the villagers purchased in the past. Both the CHW and AMW are trained to provide preventive services, services with demonstrated effectiveness but for which there is little natural demand although their cost-effectiveness is not in doubt.

Benefits

The benefits of health projects are difficult to measure, particularly in economic terms. The goal of this project is to reduce mortality and morbidity among Burma's rural poor and particularly among infants and young children. This goal is a benefit in its own right, not requiring an economic justification.

This should not be interpreted as suggesting the project won't have economic benefits, only that the principal benefit anticipated is increased social welfare; the economic benefits are of a secondary nature and cannot be quantified sufficiently well to warrant serious consideration.

There are some secondary economic benefits, however, which may be attributable to the project. Decreased labor force morbidity may lead to increased productivity, provided the other factors of production are available. Improved infant and child nutrition should also contribute in the long run to a healthier, stronger, more intelligent, and therefore, more productive future labor force.

To conclude, the most persuasive evidence of the economic soundness of the project lies in the results so far observed; i.e., the villagers themselves are arranging for some form of monetary remuneration for the PHC workers in more than half the cases, as well as raising sufficient funds for drug re-supply. This would presumably not be so widespread if the villagers did not perceive them as beneficial.

F. ENVIRONMENTAL STATEMENT

As indicated in the approved IEE which accompanied the PID, it is not anticipated that the project will have more than a marginal impact on the environment. With respect to planned sanitation activities, previous experience suggests that the CHWs will not be able to encourage the construction of enough latrines in their communities to improve the environment more than slightly.

IV. IMPLEMENTATION PLANNING

A. ADMINISTRATIVE ARRANGEMENTS

Government Administrative Arrangements

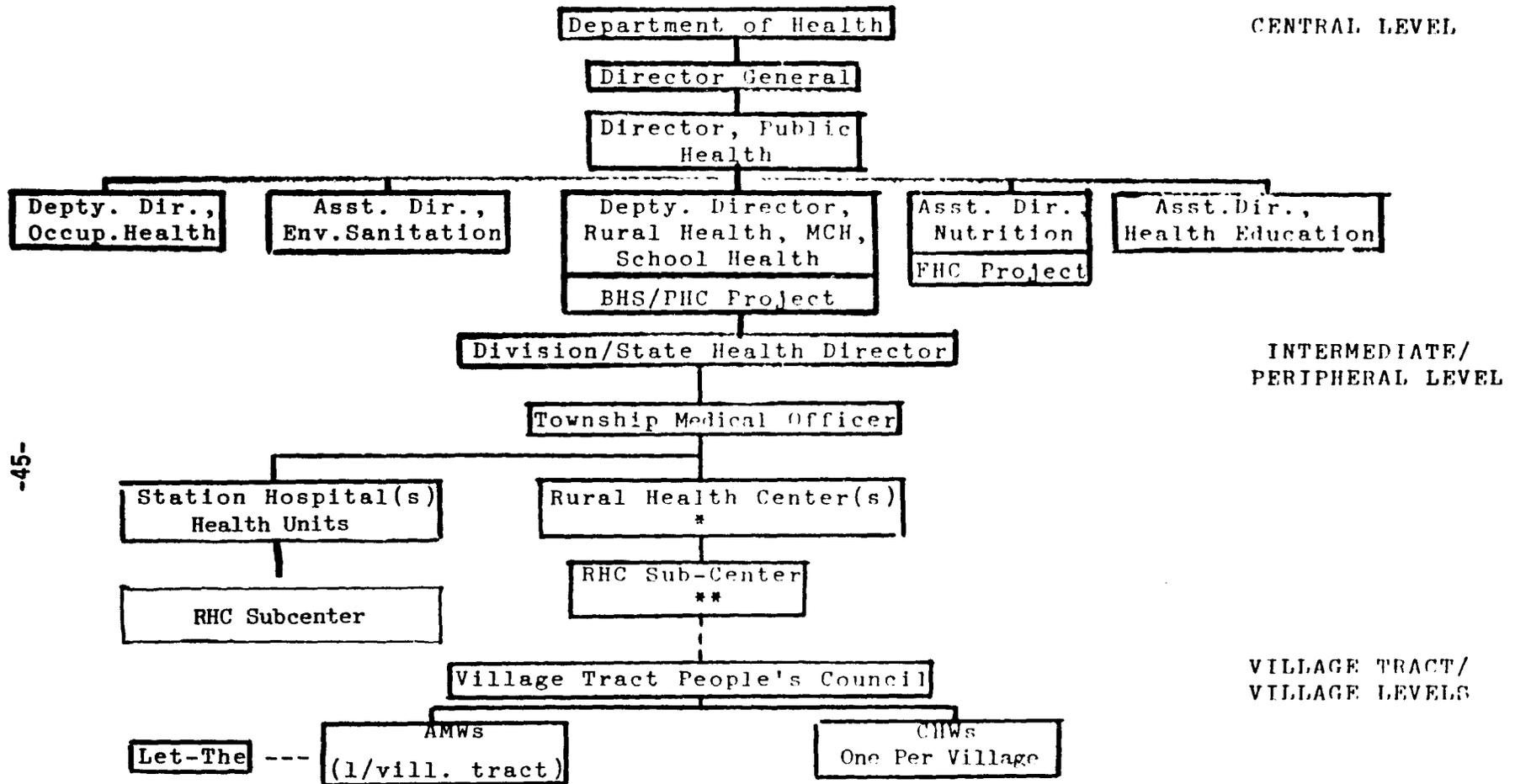
Principal coordinative and budgetary responsibility for the project lies with the Ministry of Planning and Finance, and in particular with the Director-General of the Foreign Economic Relations Department. Overall responsibility for managing and implementing the project rests with the Department of Health. The Ministry of Health (MOH) includes three departments in addition to the Department of Health (DOH): the Department of Medical Research, the Department of Medical Education and the Department of Sports and Physical Education. The Ministry of Health will assure implementation coordination with other Ministries.

The Director General (DG) of DOH has responsibility for overall health administration and planning which includes implementation of the People's Health Programme (PHP). Under the DG, a Director of Public Health oversees the Basic Health Services (BHS) and Primary Health Care (PHC) project, as well as the Family Health Care (FHC) project which incorporates nutrition activities generally and AMW training specifically. (See chart, following page.)

As overall manager of this project, the Director of Public Health is responsible for providing leadership and momentum in achieving project purposes, and for coordination and control of relevant elements of the PHP. The project will strengthen the existing Basic Health Services project and better equip station hospitals and rural health centers (RHCs). In addition, it extends the reach of services through the CHWs, AMWs, and let-thes. This will have the effect of both expanding the responsibilities of existing staff as a result of increased referrals and modifying their duties by giving more prominence to training and supervision, as well as increasing the emphasis on preventive and promotive work. DOH anticipates the possible need to reorganize to better reflect interactions among elements of the PHP in conjunction with preparation of the next Four Year Plan.

Coordination at the intermediate and peripheral levels is the responsibility of the Division/State Health Director who oversees both the Township Medical Officer (TMO) and Township Health Officer (THO). A number of programs and centers are within their jurisdictions, including rural health centers and subcenters, and most health services at the peripheral level are delivered through these centers. The extension of health services to the village level through the training and supply of CHWs, AMWs, and let-thes relies on this structure being in place. Thus both training and supervision of voluntary

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* RHCs are staffed by Medical Officers/Assistants, Lady Health Visitors, Midwives, and Public Health Supervisors I and II.

** RHC Sub-Centers are staffed by Midwives.

health workers will be the responsibility of the RHC staff who will be assisted by the THOs and by a cadre of Division/State trainer-supervisors funded under the project. CHWs and AMWs will be directly supervised by Public Health Supervisors and Midwives, respectively, from the RHC.

Recruitment of both CHWs and AMWs will, however, be the responsibility of the Village Tract People's Councils (VPCs). VPCs are informed of the PHP and their cooperation sought through Division/State, and Township People's Councils (TPCs). TPC-VPC contacts are regular and apparently effective for top-down communications. (The Burma Socialist Programme Party has cells throughout the country which regularly discuss topics suggested by the Party and bring issues to the attention of the TPCs and VPCs, as well as higher levels.) In turn, the VPCs have been effective in recruiting CHWs and AMWs, in overseeing their daily activities and, in some cases, in raising and/or managing funds generated for replacement CHW medical supplies. Also, it has been suggested that the VPC is effective in mobilizing and motivating villagers for both collective and individual service. For example, in connection with expanding the responsibilities of voluntary health workers, especially with regard to nutrition and oral rehydration, the VPCs will be enlisted to help generate support for these activities.

AID Project Administration

USAID will assist the GSRUB in project implementation to the extent desired and feasible, monitor the project, provide necessary AID approvals, participate in evaluations, and generally perform all the functions normally associated with an AID monitoring role. Monitoring will be accomplished by a USAID expatriate health advisor, a locally hired health officer (both of whom will be funded separately by AID), and through the services of a full-time procurement assistant located in the Central Medical Stores Division (CMSD) (who will be funded under the project.)

Upon authorization of the project, USAID will establish a health advisor position and request MODE clearance for this additional USDH employee. (In order to permit project activities to get underway prior to the position being established and filled, the advisor may initially have to begin work as a personal services contractor in the event it is necessary to recruit a new USDH.) In the absence of any long-term advisors funded under the project, the health advisor will be fully occupied advising the GUB regarding project implementation, and overseeing and coordinating the activities of short-term technical advisors, as well as monitoring the project for USAID. (For more detailed scopes of work, see Annex I.) To effectively accomplish these tasks with only one

advisor may require that the advisor be freed from AID administrative and program duties relating to the health field generally and even to this project specifically. The advisor's workload will have to be reviewed as the project gets underway, but it is considered critical that the US advisor not become mired in AID administrative duties related to health to the detriment of his primary advisory function. It is essential that the rest of the AID Office be able to carry out these administrative/program functions whenever necessary.

The position for a locally hired health officer (FNDH) will also be established following authorization. This individual will have major monitoring responsibilities for both training and commodities, especially in view of limitations placed by the Foreign Ministry upon travel by expatriates.

The project-funded procurement assistant will be part of the regular staff of the CMSD (along the lines of a similar individual funded by UNICEF) and will be responsible for expediting the clearance of project commodities through customs and for facilitating and monitoring their rapid distribution.

B. IMPLEMENTATION ARRANGEMENTS

Introduction

The detailed project description (Section II.B) outlines activities required to implement the CHW, AMW, and let-the training components of the project, including planned inservice training. The schedule for inception and completion of these activities appears in the Implementation Plan (Annex E).

The detailed project description and the logical framework also describe technical assistance requirements. AID/W will arrange for short-term technical advisory services by PIO/T upon request from USAID to initiate selection and contracting. Contracts for services with individuals are contemplated. In all cases DOH will approve the individual consultants for particular assignments. AID/W will make arrangements with other USG agencies as may be necessary to secure required advisory services from them. Oversight of short-term consultants will be the responsibility of the USDH health advisor.

Requirements for participant training are also set forth in the detailed project description. After training candidates have been nominated by the GSRUB, AID/W's Office of International Training (OIT) will make training arrangements under established PIO/P procedures when requested to do so by USAID.

Procurement and Distribution of Project Commodities

The major share of required dollar cost items will be procured by PIO/C from UNICEF and/or the U.S. Defense Personnel Supply Center (DPSC) for reasons set forth in the discussion of waivers which follows. Those imported items which cannot be obtained from these sources will be procured from U.S. sources through a purchasing agent chosen by the GSRUB. Burma source commodities financed with a grant of US-owned Kyats will be procured by the GSRUB using their established procedures subject to review and approval by USAID. USAID will assist the GSRUB in refining these requirements, and no assistance in local procurement will be needed.

Under the project, Code 935 source/origin procurement from UNICEF will be permitted only where UNICEF prices are one-half or less those obtainable through DPSC or commercial 000 sources. In the event that CHW and AMW kits now being supplied by UNICEF contain non-935 items, it is planned that Code 000 replacement items will be procured by the purchasing agent and shipped to the UNICEF warehouse in Copenhagen for incorporation into the kits.

If this cannot be arranged, replacement items will be shipped to Burma directly and incorporated into the kits by CMSD.

USAID will assist the GSRUB to select a procurement agent for dollar cost items not available through UNICEF or DPSC. AID/W, SER/COM will issue a PIO/C to the agent to initiate procurement. (SER/COM will also issue PIO/Cs and any other documentation necessary for initiating procurement of items to be supplied by both UNICEF and DPSC.)

Shipping containers and individual kit boxes or cases will be marked with the AID emblem. Individual items will not be marked.

All shipping arrangements for imported commodities will be according to current AID policy. Because of possible storage and distribution problems discussed below, it is desirable to keep the commodity pipeline as short as possible. Therefore, and in order to assure timely receipt and processing of commodities in accordance with proposed training schedules and re-supply requirements, air shipment will be utilized when necessary.

CMSD will be the primary GSRUB agency responsible for clearing commodities through customs, for storage at the central warehouse, and for distribution to the Mandalay subdepot, as well as to the Divisions and States which in turn supply station hospitals, RHCs and VPCs. (The VPCs have been responsible for supplying the voluntary health workers.) CMSD will arrange for all in-country transportation of commodities.

A full-time Procurement Assistant (see scope of work, Annex I) funded under the project will play a major role in assuring the movement of commodities through Burmese customs. UNICEF's experience in this regard has been highly satisfactory and no difficulties with customs are therefore anticipated.

CMSD has limited storage capacity in both its central warehouse and the Mandalay subdepot. Also, distribution resources are scarce -- four CMSD trucks are supplemented by rail, boat, and an informal network of private transport and self-service by peripheral medical personnel. Therefore, caution must be exercised in releasing commodities to avoid distribution bottlenecks. Accordingly, deliveries will be relatively frequent and phased in conformance with training targets. The Procurement Assistant will monitor deliveries, and he will report regularly on the disposition of the AID-financed commodities to USAID.

Disbursement Procedures

Disbursement of foreign exchange for commodities and consultant services (from individual contractors) will be made directly to suppliers under AID issued Direct Letters of Commitment. Disbursement for participant training and for short-term consultant services provided by USG agencies, if any, will be under standard, established AID procedures.

For local currency payments for training, commodities and salaries financed by U.S.-owned excess currency, financing will be accomplished by an initial advance payment followed by quarterly installments upon receipt of certificates that local currency was used for intended purposes. Any remaining minor disbursements by AID for local currency will be on an actual cost reimbursement basis to the GSRUB.

The exact method of disbursements of U.S.-owned Kyats, including the need for establishing any special accounts, will be subject to further discussions with the Ministry of Planning and Finance. Detailed instructions for each type of disbursement will be covered in letters of implementation.

Implementation Schedule

Detailed training schedules, and a schedule for the delivery of commodities, as well as suggested timing of short-term technical advisory services are included in the Implementation Plan (Annex F). They are predicated upon initial steps as follow:

<u>Action</u>	<u>Date</u>
1. PP submitted to AID/W; efforts to identify and/or recruit USDH advisor initiated	December 1979
2. Advice of Program Change to Congress	December 1979
3. Grant Authorization	January 1980
4. MODE Clearance for USDH obtained	January 1980
5. Grant Agreement	March 1980
6. USAID Health Advisor Assigned	March 1980
7. Initial CPs met	April 1980

8. Voluntary health worker activities initiated April 1980
9. Detailed procurement lists submitted to SER/COM;
procurement agent chosen April 1980
10. PIO/Cs issued by SER/COM to UNICEF, DPSC,
Procurement Agent May 1980

Thus, actual project implementation can begin in April 1980, the date contemplated on the individual implementation schedules. This is the start of the GSRUB's Fiscal Year 1980/81. Activities will be well underway by the early summer of 1980. Allowing for as much project experience as possible, the first annual project review will occur in the Spring of 1981.

C. EVALUATION ARRANGEMENTS

The DOH has scheduled annual evaluations of the performance and efficiency of PHP projects, including the Primary Health Care and Family Health Care projects, every Spring. Thus, regularly scheduled evaluations will occur beginning in April 1980, April 1981, and April 1982. By participating in the 1981 evaluation, USAID will have an opportunity to assess the project after its first full year of operation. By then one full complement of CHWs and AMWs will have been trained and supplied. This evaluation will also be a timely input to the development of a follow-on AID-assisted project should further assistance be planned.

The most recent (April 1979) evaluation of the PHP was designed to measure progress related to: (1) the achievement of training and management targets; and (2) fulfillment of targets for delivery of health services. As noted in the detailed project description, AID will seek to expand and strengthen the DOH evaluation system, especially with regard to impact assessment. Plans for impact evaluation have been made by DOH, and implementation is scheduled to begin in the near future.

The April 1981 evaluation will be a key element in project re-design where necessary. A similar in-depth evaluation will be scheduled for April 1982, coinciding with the end of the project. Funding included in the project, both in the AID grant and the GSRUB budget, should be adequate to cover the costs of both evaluations.

D. CONDITIONS PRECEDENT, COVENANTS, STATUS OF NEGOTIATIONS,
WAIVERS.

Conditions Precedent

To initial disbursement - designation of representatives and GSRUB assurance of adequate budgetary and staff support for the project.

To disbursements for training - training approved by GSRUB; candidates selected and approved by GSRUB; and GSRUB funding arrangements completed.

To disbursement for commodities - statement of procedures for clearing imported commodities through customs and for delivering them to States and Divisions, hospitals, and rural health centers; evidence that sufficient funds have been budgeted to pay duties or taxes charged for dollar cost imported commodities or evidence that a waiver has been granted exempting AID-financed commodities from such duties or taxes; a plan for adequate and timely resupply of voluntary health workers.

Covenants

Assurance of continuing adequate budgetary and staff support for the project.

Agreement to consult with AID semi-annually during the project for the purpose of bringing implementation and plans up to date.

Assurance that AID representatives will be afforded the opportunity at all reasonable times to inspect the project, the utilization of goods and services financed by the grant, and books, records, and other documents relating to the project.

Assurance that commodities financed under the project will be properly stored and that an in-country transportation system is in place to facilitate timely delivery of commodities at all levels.

Agreement to permit technical advisors provided under the project to enter and leave the country unhindered and free of charge at any time; agreement to enter an appropriate multiple entry permit in their passports without delay and to issue to them without delay or charge any requisite work, residence and other permits.

Agreement to permit AID to participate in the on-going GSRUB evaluation program which will include (during the project and at one or more points thereafter): (a) evaluation of progress toward attainment of the objectives of the project; (b) identification and evaluation of problem areas or constraints which may inhibit such attainment; (c) assessment of how such information may be used to help overcome such problems in this or other projects; and (d) evaluation, to the degree feasible, of the overall development impact of the project.

Negotiating Status

The project has been under intensive discussion with the Department of Health, Ministry of Health since September 1979. The project is based upon a set of GSRUB proposals presented to donors at the WHO Regional Donors' Meeting in New Delhi in July 1979, which were developed by GSRUB health officials with WHO assistance.

Based on intensive collaborative discussions between the Department of Health and AID in the course of project design, many improvements and refinements in the project have been made. The PP represents a complete agreement between AID and the Department of Health on project design and concept, project components, sharing of costs, priorities, covenants, etc. Project details have also been reviewed with and agreed to by both WHO and UNICEF.

The project has not yet been negotiated with the Ministry of Planning and Finance (MOPF), AID's principal counterpart Ministry, nor has it been submitted to the Cabinet. MOPF is of course aware in general terms of the project and cleared the submission of the project to the New Delhi meeting. A copy of the PP will be provided to both MOH and MOPF for advance review and study while AID/W reviews of the PP and Congressional Notification proceed. AID will also need to use this time frame to resolve any remaining issues on the check list as this will be the first AID project in Burma since 1962.

Following project authorization, necessary formal negotiations with the Ministry of Planning and Finance will proceed. This will include agreement on the use of US-owned Kyat to finance local costs, procedures for release of funds, coverage under the Economic Cooperation Agreement of 1957, the Project Grant Agreement Standard Provisions, and any other GSRUB undertakings in connection with the project or the aid program. Only after negotiations with the Ministry of Planning and Finance and the Ministry of Health are completed will the GSRUB present the entire agreed project to the Burmese Cabinet for final review and approval.

Waivers

To the maximum extent possible commodities will be purchased from UNICEF in Copenhagen for the following reasons:

1. Cost savings. Due to UNICEF's large volume and system of competitive bidding, UNICEF can supply most shelf item medical supplies and equipment at one-half or less of U.S. prices.

2. Compatibility of supplies. As this project is an add-on to one already being assisted by UNICEF, which will be continuing to supply drugs and equipment for training of additional CHWs already planned in GSRUB FY 80 and 81 programs, compatibility of AID-supplied commodities is important to achieve standardization. The CMSD has procedures and personnel in place for receiving, handling and distributing UNICEF kits. Further, training of CHWs is geared to teaching workers to dispense UNICEF-type drugs.

3. Non-availability from US sources. At least two important items with a total planned value of nearly \$750,000, oral rehydration salt packets and Salter scales, are not manufactured in the U.S.

For these reasons, a source/origin waiver is requested for all items contemplated for UNICEF (Code 935) procurement. Source and origin of UNICEF supplies vary by lot. In the event that some of the regular UNICEF items are of non-935 source/origin, they will be excluded from the procurement, and UNICEF will be requested to substitute items of 000 source/origin which are procured by the Purchasing Agent. With the exception of the specific 935 source/origin procurement through UNICEF, the authorized source and origin for all other dollar cost commodity procurements is Code 000.

Since the project also includes the funding, using excess US-owned Kyat, of certain costs in Burma, use of these funds for this purpose should also be authorized. No dollar grant funds will be used to finance local costs.

ANNEXES

- A. PID Approval Cable
- B. Logical Framework Matrix
- C. Project Background Data
- D. Project Implementation Data
- E. Detailed Budget and Financial Data
- F. Implementation Plan
- G. Abbreviated Commodity Lists
- H. Country Checklist / Statutory Checklist
- I. Scopes of Work
- J. Draft Project Authorization and Request
for Allotment of Funds

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Department of State

ANNEX A

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ORIGIN 118-28

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STATE 274472

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INFO OCT-88 NEA-87 CES-88 /836 R

DRAFTED BY ASIA/PO/EA: MINSING, LR
APPROVED BY AA/ASIA: JHSULLIVAN
ASIA/PO: OJORENMAN (DRAFT)
ASIA/TR: THANGOT (DRAFT)
ASIA/PT: OCHANDLER
CC/ASIA: HERRIS (SUBS)
ASIA/DP: RNALLIGAN (DRAFT)
DS/NEA: ITAYLOR (INFO)
PPG/PO: JSEGAL (INFO)
DAA/ASIA: FVSCHECK

P 192342Z OCT 79
FM SECSTATE WASHDC
TO AMEMBASSY RANGOON PRIORITY
INFO AMEMBASSY KATHMANDU PRIORITY

UNCLAS STATE 274472

AIDAC, KATHMANDU FOR DUANE SMITH

E.O. 12958: N/A

TAGS:

SUBJECT: PRIMARY HEALTH CARE (482-8881)

REFS: A) RANGOON 3663; B) STATE 285562

1. APAC REVIEWED PID FOR SUBJECT PROJECT AND RECOMMENDED APPROVAL FOR DEVELOPMENT OF PP. ISSUES, AS OUTLINED REF B, WERE RAISED FOR APAC CONSIDERATION, AND AIDREP RESPONSES, REF A, WERE VERY HELPFUL.

2. THE FOLLOWING ISSUES WERE IDENTIFIED FOR FURTHER CONSIDERATION DURING THE PROCESS OF PP PREPARATION OR FOR INCLUSION AS PART OF THE PROJECT ITSELF:

... A) PROJECT GOAL/PURPOSE: THE APAC STRONGLY ENDORSED A PROJECT GOAL OF REDUCING INFANT AND CHILD MORBIDITY/MORTALITY. THE ENSUING DISCUSSION OF HOW TO QUANTIFY GOAL ACHIEVEMENT STRESSED THE NEED FOR MEASUREMENTS OF PROGRAM ACHIEVEMENT TO FACILITATE POSSIBLE FUTURE IMPACT EVALUATIONS. A NUMBER OF POSSIBLE APPROACHES TO FACILITATE MEASUREMENT OF PROGRESS TOWARDS GOAL ACHIEVEMENT WERE DISCUSSED INCLUDING: THE COLLECTION OF BASELINE DATA IN A SAMPLE OF TOWNSHIPS IN CONJUNCTION WITH PROJECT IMPLEMENTATION; RELIANCE UPON PROXY DATA WHICH WOULD ENABLE EVALU-

ATORS TO DRAW INFERENCES ABOUT REDUCTION IN INFANT MORBIDITY/MORTALITY; AND, COLLECTION OF DATA ON INCREASED AVAILABILITY OF PRIMARY HEALTH CARE SERVICES. THE MEASUREMENT OF ACHIEVEMENT ISSUE SHOULD BE ADDRESSED IN CONNECTION WITH PP PREPARATION. ALSO, THE APAC CONSIDERED THAT THE PROJECT MIGHT INCLUDE A COMPONENT DIRECTED TOWARD IMPROVING THE BURMESE BASIC HEALTH SERVICES CAPABILITY TO MONITOR MORBIDITY/MORTALITY DATA AND TO EVALUATE EFFECTIVENESS OF PROGRAM ACTIVITIES, AND THAT THIS COMPONENT MIGHT MAKE USE OF THE BURMESE INSTITUTE OF ECONOMICS.

... B) VOLUNTEER HEALTH WORKERS: THE NEED FOR A BETTER UNDERSTANDING AT THE PP STAGE OF THE EXISTING INCENTIVE SYSTEM, INCLUDING HOW VOLUNTEER HEALTH WORKERS ARE OR CAN BE MOTIVATED TO ACCEPT CHANGING AND/OR EXPANDING FUNCTIONS, WAS DISCUSSED AT LENGTH. THE APAC WAS SUPPORTIVE OF CONCERN, REF A, PARA 4, OVER NOT JEOPARDIZING THE VOLUNTEER WORKER CONCEPT. THE QUESTION OF INCENTIVES, EXPANSION OF

ROLES, ETC. NEEDS TO BE ADDRESSED CAREFULLY IN THE PP.

... C) MANAGEMENT OF PRIMARY HEALTH CARE SYSTEM: THE APAC NOTED THAT VOLUNTEER HEALTH WORKERS ARE APPARENTLY NOT SUPERVISED NOW, A RESULT AT LEAST IN PART OF THE PHYSICAL DISTANCES BETWEEN VILLAGE LEVEL WORKERS AND TOWNSHIP/PROVINCIAL PHYSICIANS AND THE SCARCITY OF PROJECT VEHICLES. THIS WAS AN IMPORTANT FINDING OF THE PID TEAM, AND MEASURES TO IMPROVE SUPERVISION OVER TIME NEED TO BE ADDRESSED IN DESIGN. THE INFORMAL NATURE OF CURRENT PROCEDURES FOR RE-SUPPLYING VOLUNTEER WORKERS WITH DRUGS AND EQUIPMENT WAS PARTICULARLY NOTED AND THE APAC DISCUSSED THE NEED FOR SOME FORMAL MECHANISM FOR THE GUB TO UTILIZE FUNDS APPARENTLY NOW RAISED BY THE VILLAGES TO PROCURE ADDITIONAL DRUGS AND SUPPLIES AS WELL AS NEEDED PLANNING TO ENSURE THAT BPI PRODUCED DRUGS ARE AVAILABLE WHEN REPLENISHMENTS ARE NEEDED.

... D) INDIGENOUS HEALTH SYSTEM: THE APAC INDICATED THE NEED FOR A BETTER UNDERSTANDING AT BOTH THE PP STAGE AND DURING PROJECT IMPLEMENTATION OF THE INDIGENOUS HEALTH SYSTEM. ADDITIONAL INFORMATION SUPPLIED BY AIDREP, REF PARA 6, WAS APPRECIATED ALTHOUGH IT RAISED MORE QUESTIONS CONCERNING THE MANNER IN WHICH EX-TRADITIONAL HEALERS ARE REMUNERATED AFTER BECOMING CHMS.

... E) COMMODITY PROCUREMENT: THE APAC CONCURRED WITH NEED FOR A COMMODITIES SPECIALIST TO BE INCLUDED ON PP TEAM IN ORDER TO ADDRESS ISSUES RAISED REF B, PARA 7, AS WELL AS

... F) PROJECT MONITORING: IN VIEW OF GUB DISINCLINATION TO ACCEPT LONG-TERM PROJECT-FUNDED ADVISORS AND PROBABLE LIMIT OF ONE USDM TO MONITOR PROJECT, THE APAC SUGGESTED THAT THE AIDREP MIGHT WISH TO EXPLORE THE POSSIBILITY OF ACQUIRING AN ADDITIONAL HEALTH ADVISOR AS AID PSC, ALTHOUGH PRESUMABLY NOT USING PROJECT FUNDS. APAC SHARED AIDREP'S CONCERN WITH QUALITY OF USDM AND SUGGESTED THAT EFFORTS GET UNDERWAY IMMEDIATELY TO IDENTIFY INDIVIDUAL FROM WITHIN OR OUTSIDE AID TO FILL THIS POSITION ASSUMING MOCE CLEARANCE IS OBTAINED. PP SHOULD INCLUDE COMPLETE SCOPE OF WORK FOR THIS INDIVIDUAL.

... G) ROLE OF OTHER DONORS: THE APAC SUGGESTED THAT THE PP INCLUDE A FULLER DISCUSSION OF THE ROLE OF OTHER DONORS IN THE HEALTH SECTOR AND THAT THE PROJECT BE COMPATIBLE WITH ACTIVITIES FUNDED BY OTHER DONORS TO THE MAXIMUM EXTENT POSSIBLE.

... H) PARTICIPANT TRAINING: THE APAC REQUESTED THAT THE PP ADDRESS MORE FULLY THE RELEVANCE OF THE PROPOSED PARTICIPANT TRAINING.

... I) FINALLY, THE APAC NOTED ISSUES REGARDING MECHANISMS FOR LOCAL COST FINANCING, OBTAINING A JOB REQUEST FOR ASSISTANCE, AND JOB BUDGETING AND PLANNING FOR THE PROPOSED PROJECT AND ASKED THAT THEY BE ADDRESSED IN THE COURSE OF PP DEVELOPMENT.

3. FYI: IN THE COURSE OF FINAL PREPARATION OF ALL NEW PPS A/VID HAS REQUESTED THAT AN INFLATION FACTOR BE CALCULATED SEPARATELY FOR EACH LINE ITEM FOR EACH PROJECT YEAR. END FYI.

4. WITH REGARD TO PROJECT PREPARATION STRATEGY, ARRIVAL OF DESIGN TEAM BY OCTOBER 20 IMPOSSIBLE. HOWEVER, PLANS ARE UNDERWAY TO PUT TOGETHER A TEAM WHICH WOULD ARRIVE IN RANGOON 2/A NOVEMBER 1. SEE SEPTEL. VANCE

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LOGICAL FRAMEWORK

Project Title & Number: Primary Health Care, 482-0001

Life of Project: \$16,588,000
 From FY 80 to FY 81
 Total U.S. Funding: \$6,459,000
 Date Prepared: Nov. 25, 1979

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p><u>Program or Sector Goal:</u></p> <p>To reduce mortality and morbidity among Burma's rural poor and particularly among infants and children.</p>	<p><u>Measures of Goal Achievement:</u></p> <ol style="list-style-type: none"> 1. Reduction of infant mortality rate. 2. Reduction of 1-4 year age specific mortality rate. 3. Reduction of frequency of malnutrition in children. 4. Reduction in frequency of low birth weight infants. 	<ol style="list-style-type: none"> 1. Baseline surveys. 2. Routine basic health service and project statistics. 3. Periodic evaluation surveys. 	<ol style="list-style-type: none"> 1. Rural population will support and utilize primary health care services. 2. Mix of services offered, will result in decreased morbidity and mortality.
<p><u>Project Purpose:</u></p> <p>To expand the coverage and quality of Burma's primary health care (PHC) system in 147 of 287 rural townships.</p>	<p><u>Conditions that will indicate purpose has been achieved: End of project status:</u></p> <ol style="list-style-type: none"> 1. Primary health care services regularly available in more than 7,600 village tracts in the 147 project townships. 2. In-service training provided at least twice yearly to all PHC workers. 3. System for monitoring changes in selected impact indicators in PHC worker and control areas operating. 	<ol style="list-style-type: none"> 1. Training, field supervision, supply and evaluation reports of DOH. 2. Possible sample surveys of PHC workers. 3. Health Information System documents and reports. 4. Field inspections. 	<p><u>Assumptions for achieving purpose:</u></p> <ol style="list-style-type: none"> 1. Increased number of trained PHC workers will have skills and motivation necessary to increase availability of improved health care. 2. Targets for expansion and wider distribution of services/supplies met. 3. Attrition rates of PHC workers are minimal. 4. Improved quality and length of pre- and in-service

ANNEX B - LOGICAL FRAMEWORK

ANNEX B
 Page 1 of 4

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
	<p>4. Oral rehydration therapy readily available from more than 90% of PHC workers.</p> <p>5. Nutritional surveillance being carried out at regular intervals on more than 50% of children under 5 years of age.</p>		<p>training (including oral rehydration, nutritional surveillance, and other interventions) and supervision will improve quality of service.</p> <p>5. Provision of additional supplies and equipment will improve curative, preventive, referral and supervisory services.</p> <p>6. Improved monitoring and evaluation capabilities will result in an improved PHC system.</p>
<p><u>Outputs:</u></p> <p>1. An increased number of trained PHC workers supplied with necessary drugs and equipment and providing an expanded range of services.</p> <p>2. Increased capability of health services to design and implement effective training and supervision programs.</p> <p>3. Improved and expanded referral and supporting services available at better equipped RHCs and station hospitals.</p> <p>4. Increased capability of</p>	<p><u>Magnitude of Outputs:</u></p> <p>1a. 7,518 additional CHWs trained and supplied.</p> <p>b. 1,400 additional AMWs trained and supplied.</p> <p>c. 1,000 let-thes trained and supplied.</p> <p>d. 12,600 CHWs and 4,600 AMWs provided with regular in-service training.</p> <p>e. 26,750 VPC members provided orientation.</p> <p>2a. 40 additional trainers/supervisors recruited, trained and equipped.</p> <p>b. 2,335 RHC staff trained as trainers.</p> <p>c. Curricula and training aids</p>	<p>1. DOH training, personnel, supervision, evaluation and supply reports.</p> <p>2. Examination of curricula, teaching aids, impact assessment and other project documents and plans.</p> <p>3. Field visits to training sites and project area.</p>	<p><u>Assumptions for Achieving Outputs:</u></p> <p>1. Number of individuals including PHC workers, trainers, and supervisors, does not exceed training capacity.</p> <p>2. Essential supplies and equipment delivered to trainers and PHC workers, as well as referral and training facilities, on schedule.</p> <p>3. PHC workers are willing and able to undertake a wider range of tasks if provided more training and support.</p> <p>4. Additional number of trainers/supervisors will result in improved PHC worker performance.</p> <p>5. Limited transport available</p>

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p>health services to monitor and evaluate impact of the PHC/BHS program.</p>	<p>developed.</p> <p>d. Expanded job descriptions for CHWs, AMWs, and relevant BHS personnel developed and incorporated into pre- and in-service training.</p> <p>3a. 2,500 BHS workers trained in providing support to PHC program.</p> <p>b. Intravenous rehydration available at all RHCs, and township and station hospitals.</p> <p>c. 60 station hospitals equipped and supplied.</p> <p>4a. Plan for impact assessment of PHC workers on sample basis developed and approved.</p> <p>b. 20 additional health information staff for Central and Division/State levels recruited and trained.</p> <p>c. Health staff in selected sample areas trained for data collection requirements.</p> <p>d. Regular reporting and periodic reviews of monitoring and evaluation data carried out by field staff.</p> <p>e. Supplies and equipment for increasing data processing capabilities in place in Central and Division/State offices.</p>		<p>to supervisors will not unduly compromise ability to supervise.</p> <p>6. VPC members can, with orientation, provide improved PHC worker recruitment.</p> <p>7. RHC staff can be trained and motivated as effective trainers and providers of referral/supporting services.</p> <p>8. Distance is not an insurmountable barrier to utilization of referral/supporting services and facilities.</p> <p>9. Staff and equipment can be made available at all levels to increase monitoring capabilities.</p> <p>10. PHC workers can be trained and motivated to collect and report data for monitoring on a regular basis.</p> <p>11. Villages and village tracts raise sufficient funds for necessary drug resupplies.</p>

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p><u>Inputs:</u></p> <p><u>AID</u> \$6,462,000* (grant)</p> <p><u>UNICEF</u> \$1,744,000</p> <p><u>WHO</u> \$ 925,000</p> <p><u>GSRUB</u> \$2,155,000**</p> <p><u>Community Contributions</u> \$1,305,000**</p> <p>*Includes \$1,462,000 U.S. dollar equivalent of U.S. excess kyat. **U.S. dollar equivalent.</p>	<p><u>Implementation Target (Type and Quantity):</u></p> <p><u>AID</u> - Short-term advisory services - Participant training - Commodities - In-country training - Salaries and support costs</p> <p><u>UNICEF</u> - Advisory services - Commodities</p> <p><u>WHO</u> - Advisory services - Participant training</p> <p><u>GSRUB</u> - Salaries and support costs</p> <p><u>Community Contributions</u> - Payment to PHC workers and voluntary labor - Funds for drug re-supplies</p>	<p><u>AID</u> - Project Agreement - Periodic reports of monitors, advisors.</p> <p><u>UNICEF/WHO</u> - Grant documents committing funds and/or commodities.</p> <p><u>GSRUB</u> - Annual budgets. - Staffing lists. - Third Four Year Plan documents.</p> <p><u>Community Contributions</u> - Periodic reports of monitors. - DOH reports, records.</p>	<p><u>Assumptions for Achieving Inputs:</u></p> <p><u>AID</u> - Funding and project monitoring capabilities as planned.</p> <p><u>UNICEF/WHO</u> - Funds and/or commodities available as planned.</p> <p><u>GSRUB</u> - Operating budget requirements met as planned. - Staff levels approved as planned.</p> <p><u>Community Contributions</u> - Sufficient funds available; PHC workers motivated to provide some labor on a voluntary basis.</p>

ANNEX C
PROJECT BACKGROUND DATA

TABLE ONE

LEADING CAUSES OF ADMISSION IN 399 TOWNSHIP HOSPITALS (1977)

<u>Cause</u>	<u>Percent of Total Admissions</u>
Malaria	13.1
Enteritis and other diarrheal diseases	7.5
Normal delivery	5.0
Wounds and injuries	4.9
Fever - cause unknown	4.4
Abortion	3.2
Infectious hepatitis	2.7
Pulmonary tuberculosis	2.2
Pneumonia	2.0
Other respiratory diseases	2.0
Chronic bronchitis	1.9
Cutaneous infections	1.7

TABLE TWO

LEADING CAUSES OF DEATH IN 399 TOWNSHIP HOSPITALS (1977)

<u>Cause</u>	<u>Percent of Total Deaths</u>
Malaria	10.6
Enteritis and other diarrheal diseases	9.8
Pneumonia	7.1
Pulmonary tuberculosis	6.1
Fever - cause unknown	4.5
Tetanus	3.8
Symptomatic heart disease	2.4
Snake bite	2.2
Other respiratory diseases	2.2
Infectious hepatitis	1.6

Source: Hospital Morbidity Statistics, 1977, Health
Statistics Division, Department of Health,
March 1979.

TABLE THREE
ESTIMATES OF POPULATION BY AGE (IN MILLIONS)

<u>Age</u>	<u>Year</u>			
	<u>1961</u>	<u>1968</u>	<u>1975</u>	<u>1978</u>
0 - 14 years	9.0	10.7	12.4	13.2
15-59 years	12.5	14.1	16.3	17.4
60 years and above	1.2	1.6	1.8	2.0
Total:	22.7	26.4	30.5	32.6

Source: Report to the Pyithu Hluttaw on the Financial, Economic and Social Conditions of the Socialist Republic of the Union of Burma for 1979/80, Ministry of Planning and Finance, 1979, p. 11.

TABLE FOUR
HEALTH FACILITIES

<u>Facility</u>	<u>Number (1978)</u>	<u>Est. Population per Facility</u>	<u>Staff</u>
Total Hospitals	487	66,000	Variable
Station Hospitals (16 beds)	195	50,000*	1 doctor, 1-2 nurses, 1 compounder
Urban Health Centers	42		2 doctors, 2 nurses, LHV's & midwives
Maternal and Child Health Centers (towns)	250		1 LHV, 2 midwives
Rural Health Centers	1,107	22,000	1 Health Assistant, 2 public health supervisors, 1 LHV, 1 midwife
RHC sub centers	4,169	6,000	1 midwife

* Including 287 rural township hospitals

Source: Project Proposal - Community Health Workers, DOH, 1979.

TABLE FIVE
HEALTH TRAINING INSTITUTIONS

<u>Institution</u>	<u>Number</u>	<u>Duration of Course</u>	<u>Annual Estimated Output</u>
Institute of Medicine	3	4.5 years	450-500
Institute of Dental Medicine	1	4 years	50
School of Nursing	7	3 years	150
School of Lady Health Visitors	1	9 months	55
Midwifery School	16	1.5 years	450
Ayurvedic Practitioners School	1	3 years	30
Course for:			
Public Health Supervisor I	1	9 months	50
Public Health Supervisor II	1	9 months	300
Vaccinator	1	3 months	55

Source: Country Profile (Burma), WHO, 1978, p. 63.

TABLE SIX
MANPOWER RESOURCES (1977)

<u>Category</u>	<u>Number in Public Sector</u>	<u>Total Number</u>	<u>Population per Worker</u>
Doctor	2859	6153	5200
Nurse	3818	6070	5300
Health Assistant	1353	1414	
Public Health Supervisor I	370	407	
Lady Health Visitor	1180	1180	
Midwife	6166	11634	2750
Public Health Supervisor II	255	255	
Vaccinator	1222	1817	
Ayurvedic Doctor	88	5189	6200
Indigenous Practitioners		25000*	1300

* Estimated

Source: Country Profile (Burma), WHO, 1978, p. 62.

TABLE SEVEN
PEOPLE'S HEALTH PROGRAMME PRIORITIES

Major Programmes

Primary Health Care and Basic Health Services
Family Health
Expanded Programme for Immunization
Vector-borne Disease Control
Environmental Sanitation
Medical Care

Support Projects

Health Information System
Health Laboratory Services
Supply Maintenance and Repair Service
Health Practice Research
Development of Production and Quality Control of Biological and
Pharmaceutical Products
Development of Procedures and Staff Training

Source: Brief Description of the People's Health
Programmes in Burma 1977-1982, DOH, 1978.

TABLE EIGHT
PEOPLE'S HEALTH PROGRAMME TARGETS

<u>Year</u>	<u>No. of New Townships</u>	<u>No. of AMWs Trained</u>	<u>No. of CHWs Trained</u>
1978	15	300	700
1979	25	300	800
1980	30	700	1080
1981	35	900	1280
1982	42	1000	1380
Total:	147	3200	5240

Source: Country Health Program Burma: Family Health
Care and Primary Health Care and Basic Health
Services Project, DOH, 1978.

TABLE NINE
ACTIVITIES OF AUXILIARY MIDWIFE

Health education
Environmental sanitation
Communicable disease surveillance
Vital health statistics
Antenatal and postnatal care
Home delivery
Assistance with immunization
Minor treatment, management of emergencies and referral of severe cases.

Source: Country Health Program Burma:
Family Health Care, DOH, 1978.

TABLE TEN
ACTIVITIES OF COMMUNITY HEALTH WORKER

Medical care of minor ailments and first aid
Referral of severe ailments to nearest BHS unit
Assistance in communicable disease control including immunization
Motivation of the community for environmental sanitation improvement including vector control
Dissemination of health education including nutrition and family health
Assistance in family health activities
Assistance in reporting vital events
Support and assistance to the BHS staff in their activities in the community

Source: Country Health Programme Burma:
Primary Health Care and Basic Health Services Project, DOH, 1978.

ANNEX DPROJECT IMPLEMENTATION DATA

TABLE ONE
PEOPLE'S HEALTH PROGRAMME (PHP) COVERAGE

Unit	Total No.	In PHP Area	
		No.	%
Rural Townships	287	147	51
Village Tracts	13,756	7,715	56
Villages	65,326	34,051	52

TABLE TWO
AUXILIARY MIDWIFE (AMW) COVERAGE

	Village Tracts in PHP Area		% Coverage
	Total	With AMW or MW	
PHP Only	7,715	6,298	82
PHP & AID	7,715	7,715	100

TABLE THREE
COMMUNITY HEALTH WORKER (CHW) COVERAGE

	Villages in PHP Area		% Coverage
	Total	With CHW or MW	
PHP Only	34,051	8,771	26
PHP & AID	34,051	17,352	51

TABLE FOUR
SUMMARY COVERAGE AND TRAINING DATA**

Division/ State	Rural Twns.		SH	RHCs	MWs	Tot. Vill. Tracts	Uncov VTs	# AMWs *		Uncov. Vills.				# CHWs* AID- AID- covered			
	Tot.	PHP						PHP	AID	Tot. Vill.	Pre PHP	Post PHP	1982	PHP 1981	AID- 1982	% Vill. covered 1982	
DIVISIONS																	
Irrawaddy	26	13	5	75	357	970	613	437	176	6250	5893	5202	3702	691	750	750	37
Magwe	25	13	7	71	343	837	488	345	143	2771	2328	1883	561	545	710	612	80
Mandalay	25	14	11	81	403	980	580	390	190	3447	3044	2449	965	585	810	744	70
Pegu	28	14	10	61	300	713	413	287	126	3429	3129	2666	1495	463	588	483	49
Rangoon	16	14	11	62	294	645	355	251	107	2135	1841	1396	444	445	577	375	76
Saguing	38	19	11	75	360	986	626	425	201	3196	2836	2120	764	716	732	624	73
Tenasserim	10	5	2	15	75	135	60	45	15	569	494	405	120	89	150	150	79
STATES																	
Arakan	17	9	4	40	190	553	363	254	109	2028	1838	1447	669	391	400	378	64
Chin	9	5	1	29	136	287	151	104	47	677	7241	365	29	176	259	77	41
Kachin	18	9	4	26	113	346	233	158	78	1183	1070	781	347	269	243	191	66
Karen	7	5	6	27	127	327	200	139	61	1727	1600	1351	811	249	270	270	49
Kayah	6	5	4	17	60	75	29	20	9	520	460	419	92	41	170	157	72
Mon	10	10	7	40	198	390	192	126	66	1207	1009	792	159	216	370	263	84
Shan	52	12	5	30	151	471	320	231	89	4912	4761	4208	3608	343	300	300	20
TOTAL	287	147	88	649	3107	7715	4623	3212	1417	34051	57028	13766	3608	5664	11688	300	55

* In case of AMW coverage, uncovered village tracts (VTs) are those without midwives (i.e., Total Village Tracts - MWs = uncovered VTs). Together the PHP and AID will train sufficient AMWs to provide 100% coverage. In case of CHWs, uncovered villages are those without an MW or a CHW. Hence the difference between uncovered villages prior to initiation of the PHP (pre-PHP) (i.e., those without MWs) and number uncovered villages, post 1982 = total number of CHWs to be trained by PHP and AID. Percentage of villages covered in 1982 = those with a CHW, an MW or both.

** Abbreviations: PHP - under People's Health Programme; SH - Station Hospitals; RHCs - Rural Health Centers; MWs - Midwives; VTs - Village Tracts; % Vill. 1982 - %age of villages covered with either a midwife, trained CHW or both as of end of project.

TABLE FIVE

INITIAL TRAINING OF PRIMARY HEALTH CARE WORKERS

GSRUB Fiscal Year*	Financing	Number to be Trained		
		ANW	CEW	Let-The
1978-1980	GSRUB	1300	2580	60
1981	GSRUB	900	1280	
	AID	700	3294	300
1982	GSRUB	1000	1380	
	AID	700	4124	700
<hr/>				
Sub-total by	GSRUB	3200	5240	60
" by	AID	1400	7418	1000
<hr/>				
TOTAL		4600	12658	1060

* GSRUB Fiscal 1981 = April 1980 - March 1981 = Year 1 of Project
 GSRUB Fiscal 1982 = April 1981 - March 1982 = Year 2 of Project

TABLE SIX

REFRESHER TRAINING OF PRIMARY HEALTH CARE WORKERS

GSRUB Fiscal Year	No. of Workers Trained*	
	ANW	CEW
1981	2900	7154
1982	4600	12658

* Refresher training is planned for all workers each year at the rate of 12 days per year. On the assumption that the average new worker will begin work four months prior to the end of the year in which he or she has been trained, only 4 days of in-service training per year has been planned for PHC workers receiving pre-service training during that year.

DETAILED BUDGET AND FINANCIAL DATATABLE ONECALCULATION OF COMMUNITY CONTRIBUTION

	Apr. '80 - Apr. '81	Apr. '81 - Apr. '82
# OF CHWs	2580 + $\frac{4574*}{4}$	7154 + $\frac{5504*}{4}$
(1) CHW Honorarium @K50/mo.	K 2,234,000	K 5,118,000
(3) CHW drug distribution @ K 650/yr.	K 2,424,000	K 5,553,000
# OF AMWs	1300 + $\frac{1600*}{4}$	2,900 + $\frac{1700*}{4}$
(2) AMW Honorarium @K 75/mo.	K 1,530,000	K 2,992,000
(3) AMW drug distribution @ K 325/yr.	K 553,000	K 1,082,000
TOTAL Community Contribution	K 6,741,000	K 14,745,000
Or at 31.00 = K 6.5	3 1,037,000	3 2,268,000

Assumptions:

(1) Unpublished survey data indicate that a majority of CHWs are paid a small Honorarium by the local Village People's Council, many receiving as much as K100/mo.

(2) AMWs appear to receive a fairly standard "donation" for their services of 15 to 20 Kyat per delivery, the rich paying more, the poor less.

(3) The community is expected to collect funds for purchase of resupply drugs. In fact this appears to be happening, although the amount used in this calculation is only $\frac{1}{2}$ that anticipated by the project.

* CHWs AND AMWs are assumed to work only 3 months in the year they are trained

TABLE TWOCALCULATION OF GOVERNMENT CONTRIBUTION

	YEAR 1 Apr. '80 - Apr. '81	YEAR 2 Apr. '81 - Apr. '82
(1) <u>Direct Contribution - CH/s</u>	\$ 335,440	\$ 337,500
(1) Station Hospital Referral Pts.	60,910	60,910
<u>Indirect Contributions</u>		
(2) RECs	555,200	728,800
(2) Station Hospitals	25,750	51,500
Total	\$ 977,300	\$ 1,178,710

- (1) See page 8 of the Government's project proposal presented to MEO on 15 May 1979.
- (2) Without the RECs and Station Hospitals there could be no CHW and AMW program. These institutions provide practical preservice training for the CHW and AMW trainees for 21 and 90 days respectively. They provide continuing education for each at the rate of 12 days/year. They provide supervision; each REC staff member spends $\frac{1}{4}$ his time in surrounding villages doing outreach activities, activities which are more effective when done in co-operation with a resident village worker such as a CHW or AMW. They also serve as the referral point for difficult cases which the village workers have been trained to recognize and refer.

In light of the above γ of the Government Budget for RECs and station Hospitals has been credited as a Government contribution to the project.

NOTE:

The calculations in Table II are very conservative. None of the training of REC and Station Hospital personnel has been included. Nor has any of the budget of the Township hospitals which frequently serve as practical training sites when the case load at RECs or station Hospitals is insufficient. Similarly none of the overhead of Central and District/State health departments has been allocated to the government's contribution, although it is essential to the administration of the project.

TABLE THREEDETAILED SUMMARY OF AID DOLLAR BUDGET (C)

	1979-80	1980-81	FORWARD FUNDING	TOTAL
1. TECHNICAL ASSISTANCE	123,782	228,527		352,309
2. PARTICIPANT TRAINING		106,800		106,800
3. COMMODITIES	1,485,613	741,899	1,065,850	3,293,342
HEALTH WORKER/INSTITUTIONAL KITS	1,074,265	371,875	675,000	2,121,140
OTHER MEDICAL SUPPLIES	246,630	297,030	390,830	934,490
HEALTH INFORMATION SERVICES	22,280	2,400		24,680
TRAINING MATERIALS FOR TRAINING TEAMS	111,938	70,594		182,532
AUDIO VISUAL EQUIPMENT SET	30,500			30,424
4. SHIPPING (20% OF COMMODITIES + INFLATION)	309,033	170,620	238,746	718,399
5. INFLATION	81,444	175,531	127,900	384,875
TECHNICAL ASSISTANCE	21,892	64,331		86,223
PARTICIPANT TRAINING		19,224		19,224
HEALTH WORKER/INSTITUTIONAL KITS	42,971	44,625	81,000	168,596
OTHER MEDICAL SUPPLIES	9,865	34,644	46,900	91,409
TRAINING MATERIALS FOR TRAINING TEAMS	6,716	12,707		19,423
CONTINGENCY			14,000	14,000
TOTAL	1,999,872	1,423,377	1,576,176	4,999,725

TABLE FOUR

SHORT TEAM TECHNICAL ASSISTANCE BUDGET (3)

FIELD OF ASSISTANCE	1979 - 80		1980 - 81		TOTAL	
	T/M*	US \$	T/M*	US \$	T	US \$
1. TRAINING OF TRAINERS	2/5	48,558	2/4	43,344		91,902
2. NUTRITION PLANNING	1/3	28,538	1/3	30,794		59,332
3. OPERATIONAL DATA ANALYSIS	1/2	20,020	2/4	43,344		63,364
4. EVALUATION	1/3	28,538	3/6	66,016		94,554
5. LOGISTICS	1/2	20,020	2/4	43,344		63,364
6. OTHER			3/6	66,016		66,016
TOTAL	6/15	145,674	13/27	292,858		438,532
WITHOUT INFLATION		123,782		228,527		352,309
INFLATION		21,892		64,331		86,223

* T/M # OF TRIPS / # MAN MONTHS

TABLE FIVE

ASSUMPTIONS USED IN TECHNICAL ASSISTANCE BUDGET (c)

	1979 (BASE)	INFLATION RATE	1980	1981
TRAVEL COSTS				
1. AIRFARE (FROM U.S.)	\$ 2,500.00	15%	\$ 2,875.00	\$ 3,306.25
2. 2 DAYS INTERNATIONAL PER DIEM	100.00	10%	110.00	121.00
TOTAL TRAVEL COSTS	\$ 2,600.00		\$ 2,985.00	\$ 3,427.25
PERSONNEL COSTS (WORKING DAY COSTS)				
1. SALARY	\$ 160.00	7.5%	\$ 172.00	\$ 185.00
2. FRINGE BENEFITS (18% OF SALARY)	28.80		31.68	34.85
TOTAL WORKING DAY COSTS	\$ 168.80		\$ 203.68	\$ 219.85
3. PER DIEM (CALENDAR DAY COST)	\$ 30.00	0%	30.00	30.00
(TOTAL DIRECT MONTHLY COSTS)	(\$ 4,613.60)		(\$ 5,380.96)	(\$ 5,736.70)
OVERHEAD* (INSTITUTIONAL COSTS)/mo.	(\$ 2,599.52)		(\$ 3,136.72)	(\$ 3,385.69)
TOTAL MONTHLY COSTS	(\$ 7,213.12)		(\$ 8,517.68)	(\$ 9,122.39)

* Although it is planned that technical assistance will be acquired through individual contracts, overhead has been budgeted in the event that an institutional contract is awarded to assure availability of specific advisors for repeat visits related to a single project activity.

TABLE SIXPARTICIPANT TRAINING BUDGET (3)

	Person Months	(1980-81) TOTAL US \$
LONG TERM (MPH) TRAINING		
Degree and Area of Concentration		
1 x MPH in Maternal and Child Health(MCH)	12	15,000
1 x MPH in Nutrition	12	15,000
1 x MPH in Health Education	12	15,000
1 x MPH in Health Services Management	12	15,000
Total Long Term Training	48	60,000
SHORT TERM (Less than 1 year) Training		
Area of Concentration		
2 x 3 month course in Nutrition/MCH	6	15,600
2 x 3 month course in Training of Trainers	6	15,600
2 x 3 month course in Primary Health Care	6	15,600
Total ShortTerm Training	18	46,800
TOTAL ALL PARTICIPANT TRAINING	66	106,800
INFLATION (12%/YEAR x 1.5 YEARS = 18%)		19,224
GRAND TOTAL		126,024

TABLE SEVEN.

BUDGET FOR HEALTH WORKER/INSTITUTIONAL KITS (\$)

Unit Cost	1979-80		1980-81		1982+		TOTAL	
	Q*	US \$	Q*	US \$	Q*	US \$	Q*	US \$
Let-The 7.00	500	3,500	500	3,500			1000	7,000
CHW 90.00	5800	522,000	1700	153,000	5500	495,000	13000	1,170,000
AMW 152.50	1050	160,125	350	53,375	590	90,000	1990	303,500
AMW Medicine Chests 90.00	2700	243,000	500	45,000	1000	90,000	4200	378,000
AMW Training Schools 485.00	25	12,125					25	12,125
Rehydration Equipment 45.00	367	16,515					367	16,515
Station Hospitals 3900.00	30	117,000	30	117,000			60	234,000
TOTAL		1,074,265		371,875		675,000		2,121,140
Inflation Factor		1.04		1.12		1.12		
Inflation		42,971		44,625		81,000		168,596
GRAND TOTAL		1,117,236		416,500		756,000		2,289,736

* Q = Quantity

TABLE EIGHT

BUDGET FOR OTHER MEDICAL SUPPLIES (S)

	1979-80	1980-81	FORWARD FUNDED	TOTAL
1. Salts oral rehydration powder for 1 ltr. UNIPAC # 1561105 @ US \$0.08/ pkt.	41,600	92,000	185,800	319,400
2. CHLOROQUINE/ARODARQUINE tablets 150 mg botl of 1,000 UNIPAC # 1532000 @ US \$ 10.18/botl.	86,530	86,530	86,530	259,590
3. RINGER's-LACTATE solution w/iv-giving set 500 ml UNIPAC # 1560800 @ US \$ 0.79/set	118,500	118,500	118,500	355,500
TOTAL	246,630	297,030	390,830	934,490
INFLATION FACTOR	1.04	1.12	1.12	
INFLATION	9,865	34,644	46,900	91,409
GRAND TOTAL	256,495	331,674	437,730	1,025,899

TABLE NINE

EQUIPMENT BUDGET FOR RANGOON-BASED TRAINING (S)

	1979-80	1980-81	FORWARD FUNDING	TOTAL
Set of Audio - Visual Equipment for Central Training	30,500	-0-	-0-	30,500

TABLE TENBUDGET FOR USG COMMODITIES FOR HEALTH INFORMATION SERVICES (C)

	1979-80	1980-81	FORWARD FUNDING	TOTAL
1. AIR CONDITIONERS (HALL UNITS COMPUTER ROOM)	1,600			1,600
2. OSCILLOSCOPE	4,000			4,000
3. COMPUTER REPAIR+MAINTENANCE EQUIPMENT	10,000			10,000
4. DESK-TOP CALCULATORS 16(4 FOR CTR; 12 FOR STATES)	1,280			1,280
5. VOLTAGE STABILIZER	3,000			3,000
6. INK FOR OFFSET PRESS	2,400	2,400		4,800
 TOTAL H.I.S. COMMODITIES US \$	 22,280	 2,400		 24,680

TABLE ELEVENTRAINING MATERIALS BUDGET FOR DIVISION/STATE TRAINING TRIPS (C)

	1979-80	1980-81	FORWARD FUNDING	TOTAL
1. Paper and Duplicating supplies	78,410	43,350		126,760
2. Other office Supplies	5,264	3,712		13,976
3. Audio-Visual Supplies	10,912	7,273		18,185
4. Photographic Supplies	441	734		1,175
5. Overhead Projectors, parts and accessories	4,740			4,740
6. Kodak Carousel Projectors parts and accessories	4,849	906		5,755
 TOTAL	 104,616	 65,975		 170,591
Purchasing Agent's Fee (7%)	7,322	4,619		11,941
Total Including Purchasing Agent's Fee	11,939	70,594		182,532
Inflation Factor	1.06	1.18		
Inflation	6,716	13,707		19,423
 GRAND TOTAL	 118,555	 83,301		 201,956

TABLE TWELVE
BUDGET FOR IN-COUNTRY TRAINING (KYAT)

Item	1979-80	1980-81	Total
<u>PRESERVICE TRAINING OF VILLAGE WORKERS</u>			
A. AMWS			
Per Diem: (700 AMWS/yr)x(180 days/AMW)x(K10/day)	1,260,000	1,260,000	2,520,000
Other Costs (Rents, transport, etc.): K300/Town			42,900
Year 1: 59 Townships	17,700		
Year 2: 84 Townships		25,200	
B. CHWS			
Per Diem: (21 days/CHW)x(K15/day)			2,336,670
Year 1: 3,294	1,037,610		
Year 2: 4,124		1,299,060	
Other Costs (Rents, Transport, etc.):K100/RHC			81,400
Year 1: 339 RHCs	33,900		
Year 2: 475 RHCs		47,500	
<u>INSERVICE TRAINING OF VILLAGE WORKERS</u>			
A. AMWS Per Diem: (12 days*/yr)x(K10/day)			
Classes prior to 80/81: 1,300 AMWs	156,000	156,000	312,000
Class of 80/81: 1,600 AMWs	64,000	192,000	256,000
Class of 81/82: 1,700 AMWs		68,000	68,000
B. CHWs Per Diem: (12 days*/yr)x(K10/day)			
Classes prior to 80/81: 2,580 CHWs	309,600	309,600	619,200
Class of 80/81: 4,574 CHWs	182,960	548,880	731,840
Class of 81/82: 5,504 CHWs		220,160	220,160
<u>DISTRICT/STATE TRAINING TEAMS</u>			
A. Salaries of New People			
28 Doctors @ 600K/Mo x 12 Mos/Yr	16,800	16,800	33,600
12 PHNs @ 400K/Mo x 12 Mos./Yr	4,800	4,800	9,600
B. Preservice Training (60 People)**			
Per Diem (60x42 days x K10/day)	25,200		25,200
Travel Allowance (60 people x K200/person)	12,000		12,000
Other (Rents, transport, etc.)	1,500		1,600

** 40 New People + 14 existing health educators + 2 existing PHNs + 4 existing resource persons.

* In the year they complete preservice training they average only 4 days of Inservice Training.

TABLE TWELVE, Cont.
BUDGET FOR IN-COUNTRY TRAINING (KYAT)

Item	1979-80	1980-81	Total
C. Materials Development Workshops (60 People)			
Per Diem (60x45 days x K10/day)	27,000	27,000	54,000
Travel Allowance (60 People x K200/person)	12,000	12,000	24,000
D. Training + Supervisory Activities			
Per Diem (56 people x 8 trips x 15 days x K10)	67,200	67,200	134,400
Travel Allowance (56 x 8 trips x K30)	13,440	13,440	26,880
Per Diem (4 people x 2 trips x 10 days x K10)	800	800	1,600
Travel Allowance (4 x 2 trips x K200)	1,600	1,600	3,200
<u>TRAINING OF TOWNSHIP TRAINERS (5 Persons/RHG)</u>			
Per Diem: (339 RHGs x 5 x 4 days x K10)	67,800		67,800
(148 RHGs x 5 x 4 days x K10)		27,600	27,600
Other (Rents, etc.) (70 townships x K100)	7,000		7,000
(35 townships : K100)		3,500	3,500
<u>VILLAGE PEOPLES COUNCIL ORIENTATION (2 Members/CHW+AMW)</u>			
Per Diem (1,600 + 4,574) x 2 x 2 days x K10)	246,960		246,960
(1,700 + 5,504) x 2 x 2 days x K10)		288,160	288,160
TOTAL SALARIES	21,600	21,600	43,200
TOTAL PER DIEM + HONORARIA	3,445,130	4,464,460	7,909,590
TOTAL TRAVEL ALLOWANCE	39,040	27,040	66,080
TOTAL OTHER COSTS	60,200	76,200	136,400
GRAND TOTAL	3,565,970	4,589,300	8,155,270
<u>LET-THE TRAINING OF TRAINERS</u>			
Per Diem: 28 Key Figures x K20 x 7 days)	3,920		
Per Diem: (108 LHVs + 486 MWs) x K20 x 21 days)	249,480		
Honoraria: 18 Coordinators x K30 x 21 days	11,340		
Other Costs			
Firewood: 5 Bundles x K2 x 21 days x 18 courses	3,780		
Soap: 1 Bar x K10 x 21 days x 18 courses	3,780		
Fuel: 10 Gallons x K4 x 180 visits	7,200		
Contingency: K350 x 18 courses	6,300		
TOTAL	285,800		285,300

TABLE THIRTEENBUDGET FOR ASSISTANCE TO THE HEALTH INFORMATION SECTION - EVALUATION (MYAT)

ITEM	1980-1981	1981-1982	TOTAL
DIVISION/STATE CLERKS FOR HIS			
A. SALARIES (14 x 12 mos. x K210/mo)	35,280	35,280	70,560
B. PER DIEM (14 x 12 mos. x 5 DAY/MO. x K10/DAY)	8,400	8,400	16,800
C. TRAVEL ALLOWANCE (14 x 12 MOS x 1 TRIP x K50/TRIP)	8,400	8,400	16,800
D. WORKSHOP IN RANGOON			
PER DIEM (14 x 15 DAYS x K10/DAY)	2,100	2,100	4,200
TRAVEL ALLOWANCE (14 x K200)	2,800	2,800	5,600
CENTRAL OFFICE CLERKS			
A. SALARIES (8 x 12 MOS. x K185/MO)	17,760	17,760	35,520
ANN INCENTIVES			
A. SALARY FOR REPORTING (210 x 12 MOS. x K50/MO)	126,000	126,000	252,000
B. WORKSHOPS IN DIVISION CTR.			
PER DIEM (210 x 7 DAYS x K10/DAY)	14,700	14,700	29,400
TRAVEL ALLOWANCE (210 x K30/TRIP)	6,300	6,300	12,600
SUBTOTAL PERSONNEL COSTS - MYAT	221,740	221,740	443,480
OTHER			
OFFICE SUPPLIES-SERVICES	14,000	14,000	28,000
TOTAL	235,740	235,740	471,480

TABLE FOURTEENBUDGET FOR AD-HOC SURVEYS - EVALUATION (KYAT)

ITEM	1980-81	1981-82	TOTAL
3 AD-HOC SURVEYS PER YEAR			
INTERVIEWERS - 28 1 MONTH EACH			
SALARIES 3 x 28 x K 185/MO.	15,540	15,540	31,080
PER DIEM 3 x 28 x 30DAYS x K10/DAY	25,200	25,200	50,400
TRAVEL ALLOWANCE 3 x 28 x 1 TRIP x K350/TRIP	29,400	29,400	58,800
OFFICE SUPPLIES - K6000/SURVEY	18,000	18,000	36,000
COMPUTER SERVICES/SUPPLIES - K14,000/SURVEY	42,000	42,000	84,000
TRAINING COSTS - K3,500/SURVEY	10,500	10,500	21,000
TOTAL	140,640	140,640	281,280

TABLE FIFTEEN
OTHER KYAT COSTS

	1979-80 KYAT	1980-81 KYAT	TOTAL KYAT
1. LOGISTICS/WAREHOUSE SUPPORT PERSON	15,000	15,000	30,000
2. BURMESE FIRST-AID BOOKLETS @ K5	29,000	36,000	65,000
3. D/S TT LOCALLY PURCHASED OFFICE SUPPLIES	30,000	30,000	60,000
4. PRINTING SERVICES FOR GROWTH CHARTS	150,000		150,000
TOTAL	224,000	81,000	305,000

	PROJECT YEAR I												PROJECT YEAR II											
	1980						1981						1982											
	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M
TRAINING-RELATED:																								
Selection/Posting of D/SPTs	_____																							
Training of D/SPTs (in 2 batches of 28, 6 wks. each)			_____																					
Curriculum materials and orientation materials development workshops																								
D/SPTs conduct trainer-of-trainers programs																								
VFC orientation in CHW/AMW selection, use of oral rehydration salts																								
VFC selection of CHWs/AMWs			_____																					
Training of AMWs by TMOs (3 mos.) & RHCs (3 mos.)																								
Training of CHWs by RHCs																								
Observation/supervision of field activities by D/SPTs																								
Development of Materials/Training of let-thes																								

ANNEX F
IMPLEMENTATION PLAN

	PROJECT YEAR I												PROJECT YEAR II											
	1980						1981						1982											
	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M
COMMODITIES DELIVERIES																								
Training Materials						X																		
Hospital Equipment Units (10 each time)									X		X	X												
CHW kits (2,000 each time, except 1,500 April 1981)									X		X	X												X
AMW kits (4,600)			X																					X
Let-Us kits (1,000)			X																					X
SHORT TERM TECHNICAL ADVISORY SERVICES																								
Training of Trainers (9 pm)																								
Nutrition Planning (6 pm)																								
Nutritional Data Analysis (6 pm)																								
Evaluation (9 pm)																								
Other (6 pm)																								

ANNEX G - ABBREVIATED COMMODITY LISTS

<u>KITS*</u>	<u>COST US \$**</u>
I. TRADITIONAL MIDWIFE (LET-THE)	7 each
II. COMMUNITY HEALTH WORKER (CHW)	90 each
A. CHW MEDICINE CHEST - \$70.00	
B. CHW FIRST-AID - \$20.00	
III. AUXILIARY MIDWIFE (AMW)	153 each
A. AMW MEDICINE CHEST - \$90.00	
B. AMW MIDWIFERY KIT - \$42.50	
C. AMW NURSING KIT - \$20.00	
IV. REHYDRATION EQUIPMENT	45 each
V. STATION HOSPITAL EQUIPMENT	3,900
VI. AMW TRAINING SCHOOL SET	485
VII. AUDIO-VISUAL SET FOR CENTER TRAINING	30,500
VIII. TRAINING MATERIALS SETS FOR D/STTs	202,000

*For selective itemization see following pages; detailed commodity lists to form basis of PIO/Cs can be obtained from USAID.

**Total costs presume UNICEF as procurement source whenever its prices are 1/2 or less of 000 prices; totals include 7% fee for procurement agent's services.

I. TRADITIONAL MIDWIFE (LET-THE) KIT

Drugs - Gentian Violet
Supplies
Equipment

IIA. CHW MEDICINE CHEST

Drugs - Sulfadimidine, Piperazine, Iron/Folate,
Oralyte, Eye Ointment, Aspirin, Antiseptic
Cream, Benzyl Benzoate, Gentian Violet,
Vitamin B.
Supplies
Equipment

IIB. CHW FIRST AID KIT

Drugs - Antiseptic Cream, Mercurachrome
Dressings and other supplies
Snakebite kit
Flashlight
Equipment

IIIA. AMW MEDICINE CHEST

Drugs - Multivitamin/Iron/Folate, Ergometrine,
Vitamin A, Oralyte, Aspirin, Sulfadimidine,
Piperazine, Eye Ointment, Gentian Violet.
Equipment - Salter Portable Scale
Adult Scale
6' Folding Ruler

IIIB. AMW MIDWIFERY KIT

Drugs - Ergometrine
Supplies
Equipment

IIIC. AMW NURSING KIT

Supplies
Equipment

IV. REHYDRATION EQUIPMENT SET

Nasal Tubes
Scalp Vein and Cut-down Sets

V. STATION HOSPITAL EQUIPMENT SET

Anesthesia Equipment
Labor and Delivery Bed
Refrigerator
Sterilizing Equipment
Diagnostic Set
Examining Table
Microscope
Surgical Equipment
Generator, gasoline
Operating Light
Hospital Supplies
Tracheotomy Unit
Suction Unit
D&C Set
Autopsy Set

VI. AMW TRAINING SCHOOL SET

Charts and other Aids
Anatomic Models

VII. AUDIO-VISUAL SET FOR CENTER TRAINING

Plain Paper Copier and Parts
Overhead projectors
Tape Recorders and Speakers
Assorted related equipment and supplies

VIII. TRAINING MATERIALS SETS FOR D/STT

Stencils and paper (of suitable quality for
printing/reproduction)

Audio-Visual supplies including artists'
supplies, film and developing kits, overhead
and slide projectors.

I. COUNTRY CHECKLIST

A. GENERAL CRITERIA FOR COUNTRY ELIGIBILITY

1. FAA Sec. 116. Can it be demonstrated that contemplated assistance will directly benefit the needy? If not, has the Department of State determined that this government has engaged in a consistent pattern of gross violations of internationally recognized human rights?

Yes.

2. FAA Sec. 481. Has it been determined that the government of recipient country has failed to take adequate steps to prevent narcotics drugs and other controlled substances (as defined by the Comprehensive Drug Abuse Prevention and Control Act of 1970) produced or processed, in whole or in part, in such country, or transported through such country, from being sold illegally within the jurisdiction of such country to U.S. Government personnel or their dependents, or from entering the United States unlawfully?

No.

3. FAA Sec. 620(b). If assistance is to a government, has the Secretary of State determined that it is not controlled by the international Communist movement?

Yes.

4. FAA Sec 620(c). If assistance is to government, is the government liable as debtor or unconditional guarantor on any debt to a U.S. citizen for goods or services furnished or ordered where (a) such citizen has exhausted available legal remedies and (b) debt is not denied or contested by such government?

No.

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

Status is under active review by State/L and EB.

6. FAA Sec. 620(a), 620(f); FY 79 App. Act, Sec. 108, 114 and 606. Is recipient country a Communist country? Will assistance be provided to the Socialist Republic of Vietnam, Cambodia, Laos, Cuba, Uganda, Mozambique, or Angola?

No.

7. FAA Sec. 620(i). Is recipient country in any way involved in (a) subversion of, or military aggression against, the United States or any country receiving U.S. assistance, or (b) the planning of such subversion or aggression?

No.

8. FAA Sec. 620(j). Has the country permitted, or failed to take adequate measures to prevent, the damage or destruction, by mob action, of U.S. property?

No.

9. FAA Sec. 620(l). If the country has failed to institute the investment guarantee program for the specific risks of expropriation, inconvertibility or confiscation, has the AID Administrator within the past year considered denying assistance to such government for this reason?

A statement is being drafted for the signature of AA/ASIA recommending that an OPIC agreement not be made a pre-requisite to an AID program, although it is intended that such an agreement be offered at a later date.

10. FAA Sec. 620(o); Fishermen's Protective Act of 1967, as amended, Sec. 5. If country has seized, or imposed any penalty or sanction against, any U.S. fishing activities in international waters (a) has any deduction required by the Fishermen's Protective Act been made? and (b) has complete denial of assistance been considered by AID Administrator?

N/A

11. FAA Sec. 620; FY 79 App. Act, Sec. 603. (a) Is the government of the recipient country in default for more than 6 months on interest or principal of any AID loan to the country? (b) Is country in default exceeding one year on interest or principal on U.S. loan under program for which App. Act appropriates funds?

The GUB is not in default of AID loan repayment.

12. FAA Sec. 620(s). If contemplated assistance is development loan or from Economic Support Fund, has the Administrator taken into account the percentage of the country's budget which is for military expenditures, the amount of foreign exchange spent on military equipment and the amount spent for the purchase of sophisticated weapons systems? (An affirmative answer may refer to the record of the annual "Taking Into Consideration" memo: "Yes, as reported in annual report on implementation of Sec. 620(s)."

7. FAA Sec. 620(i). Is recipient country in any way involved in (a) subversion of, or military aggression against, the United States or any country receiving U.S. assistance, or (b) the planning of such subversion or aggression?

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This report is prepared at time of approval by the Administrator of the Operational Year Budget and can be the basis for an affirmative answer during the fiscal year unless significant changes in circumstances occur.)

N/A.

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

No.

14. FAA Sec. 620(u). What is the payment status of the country's U.N. obligations? If the country is in arrears, were such arrearages taken into account by the AID Administrator in determining the current AID Operational Year Budget?

GUB is not known to be in arrears.

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

No.

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

No.

B. FUNDING CRITERIA FOR COUNTRY ELIGIBILITY

1. Development Assistance Country Criteria

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

Third Four Year Plan involves the poor in development; criteria to assess commitment have been established and taken into account in relevant program areas.

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

Project is anticipated to indirectly build motivation for smaller families through reduction of infant and childhood mortality rates.

2. Economic Support Fund Country Criteria

N/A

II. PROJECT CHECKLIST

A. GENERAL CRITERIA FOR PROJECT

1. FY 79 App. Act Unnumbered; FAA Sec. 653(b); Sec. 634A. (a) Describe how Committees on Appropriations of Senate and House have been or will be notified concerning the project; (b) is assistance within (Operational Year Budget) country or international organization allocation reported to Congress (or not more than \$1 million over that figure)?

- (a) Congress will be notified by Advice of Program Change;
- (b) The project is to be included in FY 80 O.Y.B.

2. FAA Sec. 611(a)(1). Prior to obligation in excess of \$100,000, will there be (a) engineering, financial, and other plans necessary to carry out the assistance and (b) a reasonably firm estimate of the cost to the U.S. of the assistance?

Project Paper is the financial plan and contains the cost estimates.

3. FAA Sec. 611(a)(2). If further legislative action is required within recipient country, what is basis for reasonable expectation that such action will be completed in time to permit orderly accomplishment of purpose of the assistance?

No action required.

4. FAA Sec. 611(b); FY 79 App. Act Sec. 101. If for water or water-related land resource construction, has project met the standards and criteria as per the Principles and Standards for Planning Water and Related Land Resources dated October 25, 1973?

N/A

5. FAA Sec. 611(e). If project is capital assistance (e.g., construction), and all U.S. assistance for it will exceed \$1 million, has Mission Director certified and Regional Assistant Administrator taken into consideration the country's capability effectively to maintain and utilize the project?

N/A.

6. FAA Sec. 209. Is project susceptible of execution as part of regional or multilateral project? If so why is project not so executed? Information and conclusion whether assistance will encourage regional development programs.

Project will be implemented in conjunction with complementary UNICEF and WHO-funded projects.

7. FAA Sec. 601(a). Information and conclusions whether project will encourage efforts of the country to: (a) increase the flow of international trade; (b) foster private initiative and competition; (c) encourage development and use of cooperatives, credit unions, and savings and loan associations; (d) discourage monopolistic practices; (e) improve technical efficiency of industry, agriculture and commerce; and (f) strengthen free labor unions.

- (a) No.
- (b) Will foster initiative because villages recruit and support voluntary health workers and raise funds for drug supplies.
- (c) No.
- (d) No.
- (e) N/A.
- (f) N/A.

8. FAA Sec. 601(b). Information and conclusion on how project will encourage U.S. private trade and investment abroad and encourage private U.S. participation in foreign assistance programs (including use of private trade channels and the services of U.S. private enterprise).

U.S. suppliers will supply all technical advisory services and a portion of FX commodities.

9. FAA Sec. 612(b); Sec. 636(h). Describe steps taken to assure that, to the maximum extent possible, the country is contributing local currencies to meet the cost of contractual and other services, and foreign currencies owned by the U.S. are utilized to meet the cost of contractual and other services.

The GUB will contribute more than 25% of project costs; US owned excess foreign currency will be utilized for all local costs.

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?

Yes; arrangements are being made to secure release under Mondale-Poage authority of PL 480.

11. FAA Sec. 601(e). Will the project utilize competitive selection procedures for the awarding of contracts, except where applicable procurement rules allow otherwise?

Yes.

12. FY 70 App. Act Sec. 608. If assistance is for the production of any commodity for export, is the commodity likely to be in surplus on world markets at the time the resulting productive capacity becomes operative, and is such assistance likely to cause substantial injury to U.S. producers of the same, similar, or competing commodity?

N/A.

B. FUNDING CRITERIA FOR PROJECT

1. Development Assistance Project Criteria

a. FAA Sec. 102(b); 111; 113; 281a. Extent to which activity will (a) effectively involve the poor in development, by extending access to economy at local level, increasing labor-intensive production and the use of appropriate technology, spreading investment out from cities to small towns and rural areas, and insuring wide participation of the poor in the benefits of development on a sustained basis, using the appropriate U.S. institutions; (b) help develop cooperatives, especially by technical assistance, to assist rural and urban poor to help themselves toward better life, and otherwise encourage democratic private and local governmental institutions; (c) support the self-help efforts of developing countries; (d) promote the participation of women in the national economies of developing countries and the improvement of women's status; and (e) utilize and encourage regional cooperation by developing countries?

(a) Purpose of the project is to extend health services to the village level and to involve a wide segment of the poor in the project on a sustained basis.

(b) N/A.

(c) Yes

(d) Yes

(e) Yes

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

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

Purpose of project is to provide low-cost integrated delivery of health and nutrition services to Burma's rural poor, with particular emphasis on the needs of mothers and children age 0-5, using voluntary health workers.

c. (107) Is appropriate effort placed on use of appropriate technology?

Yes.

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

Yes.

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

No.

f. FAA Sec. 281(b). Describe extent to which program recognizes the particular needs, desires, and capacities of the people of the country; utilizes the country's intellectual resources to encourage institutional development; and supports civil education and training in skills required for effective participation in governmental and political processes essential to self-government.

This GUB project was designed with regard for the particular needs, desires and capacities of Burma's population; it's purpose is to extend health services to the rural poor by involving voluntary health workers at the village level.

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

N/A.

2. Development Assistance Project Criteria (Loans Only)

N/A.

ANNEX I

Scopes of Work

I. USDH Health Advisor (Funded internally by AID)

A. Monitoring

1. Review materials submitted in fulfillment of conditions precedent and covenants, advising the GSRUB and AID on the adequacy and timeliness of such material and on what steps should be taken to correct deficiencies.

2. Review Burma's progress in achieving project purposes, advising the GSRUB and AID whether progress is adequate and on schedule and what steps should be taken to correct deficiencies.

3. Review all project reports; conduct personal inspections.

4. Participate in evaluations.

B. Advisory

1. Maintain continuous liaison with key Burmese involved in project implementation and design of follow-on projects.

2. Serve as a technical and professional advisor to Burmese project implementors on organizational questions, planning, training, supply evaluation and other issues related to project implementation.

3. Participate whenever appropriate with Burmese project implementors in assessment and solution of technical and operational problems which arise in the course of project implementation.

4. Assist project implementors in suggesting rescheduling or reprogramming of project inputs where necessary to support the project purpose.

5. Oversee development of a follow-on project, if any.

6. Maintain liaison with WHO, UNICEF, and other donors.

C. Coordination

1. Identify and arrange for all short-term consultant services funded under the project.
2. Oversee all short-term technical advisors.

II. Local Hire Health Officer (Funded internally by AID)

A. Monitoring

1. Review progress in meeting project purposes.
2. Conduct personal inspections of project-funded training activities as well as the foreign exchange-financed commodities.
3. Participate in evaluations.

B. Advisory

1. Maintain continuous liaison with key Burmese involved in project implementation.
2. Serve as a technical and managerial advisor to Burmese project implementors on organizational questions, planning, training, supply and other related issues.

III. Project-funded Procurement Assistant (Located in GSRUB Central Medical Stores (CMSD))

1. Assist CMSD in clearance of AID-financed commodities through customs.
2. Oversee distribution of AID-financed commodities to hospitals and RHCs.
3. Report regularly to AID on the disposition of commodities.

IV. U.S. Short-term Advisors - see detailed project description for illustrative areas of expertise. (Exact short-term needs will be determined by the long-term direct-hire, in conjunction with DOH officials.)

DRAFT

PROJECT AUTHORIZATION AND REQUEST FOR ALLOTMENT OF FUNDS

PART II

Country: Burma

Project: Primary Health Care

Project No: 482-0001

Pursuant to Part I, Chapter 1, Section 104 of the Foreign Assistance Act of 1961, as amended, I hereby authorize a Grant to the Government of the Socialist Republic of the Union of Burma (the "Cooperating Country") of not to exceed Two Million United States dollars (\$2,000,000) (the "Authorized Amount") to help in financing certain foreign exchange costs of goods and services and a Grant of not to exceed Six Hundred and Ninety Thousand United States Dollar Equivalent of United States-Owned Kyat (\$690,000) (the "Authorized Amount") to help in financing certain local costs of goods and services for the project as described in the following paragraph:

The project (hereinafter referred to as the "Project") is designed to assist the Government of the Socialist Republic of the Union of Burma ("GSRUB") in expanding the coverage and quality of Burma's primary health care system in 147 of 287 rural townships. This will be done through: increasing the availability of trained primary health care workers; improving and expanding supervision of primary health care workers; expanding the range of disease control activities carried out by primary health care workers; strengthening supporting and referral services available at rural health centers and station hospitals; and, increasing the capability of the health services to monitor the primary health care and basic health services project.

I approve the total level of A.I.D. appropriated funding planned for this Project of not to exceed Five Million United States Dollars (\$5,000,000) and an additional One Million Five Hundred Thousand United States Dollar Equivalent of United States-owned Kyat (\$1,500,000), including the funding authorized above, which will be entirely grant-funded, during the period FY 1980-81. I approve further increments during the period of grant funding up to this total, subject to the availability of funding in accordance with A.I.D. Allotment procedures.

I hereby authorize the initiation of negotiation and execution of the Project Agreement by the officer to whom such authority has been delegated in accordance with A.I.D. regulations and Delegations of Authority subject to the following essential terms and major conditions together with such other terms and conditions as A.I.D. may deem appropriate:

a. Source and Origin of Goods and Services

Except for ocean shipping, goods and services financed under the Grant 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. Training in the United States and in third countries shall be undertaken in accordance with the provision of A.I.D. Handbook Number 10. Ocean shipping financed under the Grant shall be procured in the United States except as A.I.D. may otherwise agree in writing.

b. Initial Conditions Precedent to Disbursement

1. Prior to any disbursement, or the issuance of any commitment documents under the Project Agreement, for any expenditure of funds, the Cooperating Country shall designate representatives to undertake the Project and to coordinate actions with A.I.D.

2. Prior to any disbursement, or the issuance of any commitment documents under the Project Agreement, for the procurement of commodities, the Cooperating Country shall budget sufficient funds to pay any duties or taxes levied against the commodities or it shall provide evidence satisfactory to A.I.D. that a waiver has been granted exempting AID-financed commodities from such duties or taxes.

c. Covenants

1. The Cooperating Country covenants to provide continuing adequate budgetary and staff support for the Project.

2. The Cooperating Country covenants to afford A.I.D. representatives the opportunity at all reasonable times to inspect the Project and the utilization of goods and services funded under the Grant.

3. The Cooperating Country covenants to expeditiously process and properly store and distribute all goods financed under the Grant.

d. Waiver to Code 935

On the basis that certain goods related to improving basic primary health care are not available in the United States or the Cooperating Country, and on the basis that in the interest of substantial cost savings and compatibility of supplies certain goods must be supplied by the United Nations Children's Fund ("UNICEF"), goods financed under the Project may be procured from countries included in A.I.D. Geographic Code 935; Provided however, that the items to be procured from UNICEF are supplied at half or less of the cost of these items if procured from United States sources.

John H. Sullivan
Assistant Administrator
Bureau for Asia



ANNEX J

THE SOCIALIST REPUBLIC OF THE UNION OF BURMA
MINISTRY OF PLANNING AND FINANCE
FOREIGN ECONOMIC RELATIONS DEPARTMENT
OFFICE OF THE MINISTERS
RANGOON

Dated, the 12 August 1980.

Mr. David N. Merrill
AID Representative
Rangoon

Dear Mr. Merrill,

I wish to refer to your letter of December 31, 1979, forwarding the draft Project Paper for the Primary Health Care Project (the Project), as well as your letter of July 4, 1980, relating to contributions by the United States Agency for International Development for the Project, and to advise you that the Project, with modifications proposed to you by the Department of Health, has now been approved by our authorities. Accordingly, I should like to make a formal request on behalf of the Government of the Socialist Republic of the Union of Burma for a grant of \$ 5 million (United States dollars five million) from the United States Agency for International Development to meet the foreign exchange costs of the Project over a period of two years.

I should also like to suggest that a draft text of the project agreement may be furnished at your earliest convenience for further consideration.

Yours sincerely,

(Thein Lyint)
Director-General