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UNCLASSIFIED 3830062004201

AGENCY FOR INTERNATIONAL DEVELOPMENT
WASHINGTON D.C. 20523

PROJECT PAPER

SRI LANKA - NATIONAL INSTITUTE OF HEALTH SCIENCES

383-0062

UNCLASSIFIED

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AGENCY FOR INTERNATIONAL DEVELOPMENT
PROJECT DATA SHEET

1. TRANSACTION CODE: **A** (A = All, C = Change, D = Disorg)
 Amendment Number: _____
 PROJECT NUMBER: **383-0062**
 BUREAU/OFFICE: **ASIA**
 PROJECT TITLE: **National Institute of Health Sciences**

2. COUNTRY/ENTITY: **SRI LANKA**
 3. PROJECT NUMBER: **383-0062**
 4. BUREAU/OFFICE: **ASIA**
 5. PROJECT TITLE: **National Institute of Health Sciences**
 6. PROJECT ASSISTANCE COMPLETION DATE (PACD): MM DD YY **08 31 84**
 7. ESTIMATED DATE OF COMPLETION (Under "B" column, enter 1, 2, 3, or 4)
 A. Initial FY: **80** B. Other: **4** C. Other: **8 2**

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

A. FUNDING SOURCE	FISCAL YEAR 80				LIFE OF PROJECT	
	B. FX	C. L/C	D. Total	E. FX	F. L/C	
AID Appropriated Total	50	450	500	340	1860	2200
(Grant)	(50)	(450)	(500)	(340)	(1860)	(2200)
(Loan)	()	()	()	()	()	()
Other U.S.						
1. Host Country		300	300			1220
2. Other Donor(s)	350	150	500			1580
TOTALS	400	900	1300			5000

9. SCHEDULE OF AID FUNDING (PACD)

A. APPROPRIATION	B. PRIMARY PURPOSE CODE	C. PRIMARY TECH. CODE		D. OBLIGATIONS TO DATE		E. AMOUNT APPROVED (PACD)		F. LIFE OF PROJECT	
		1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan
(1) HE	513	562				500		2200	
(2)									
(3)									
(4)									
TOTALS						500		2200	

10. SECONDARY TECHNICAL CODES (maximum 6 codes of 3 positions each): **510 540**
 11. SECONDARY PURPOSE CODE: **533**
 12. SPECIAL CONCERNS CODES (maximum 7 codes of 4 positions each)
 A. Code: **INTR TNG NUIR**
 B. Amount: _____

13. PROJECT PURPOSE (maximum 480 characters):
 To expand the physical facilities of the National Institute of Health Sciences at Kalutara in support of a multi-donor program to train the quantity and quality of health care workers required to improve GSL health delivery services and environmental sanitation.

14. SCHEDULED EVALUATIONS

Interim	MM YY	MM YY	Final	MM YY
	12 81	12 83		09 84

15. SOURCE RANGE OF FUNDS AND FINANCING: 000 011 Local Other (Specify)

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

17. APPROVED BY: **S.J. Littlefield**
 Signature: *[Signature]*
 Title: **Director, USAID/Sri Lanka**
 Date Signed: **08/25/84**
 Date of Implementation: _____

PROJECT AUTHORIZATION

Name of Country: Sri Lanka

Name of Project: National Institute of Health Sciences

Number of Project: 383-0062

1. Pursuant to Section 104 of the Foreign Assistance Act of 1961, as amended, I hereby authorize the National Institute of Health Sciences Project for Sri Lanka involving planned obligations of not to exceed \$2,200,000 in grant funds over a three year period from date of authorization, subject to the availability of funds in accordance with the A.I.D. OYB/allotment process, to help in financing foreign exchange and local currency costs for the project.

2. The project consists of expansion of the physical facilities of the National Institute of Health Sciences (NIHS) in support of the multi-donor program to increase the capacity of the NIHS to train the quantity and quality of health care workers required to improve Sri Lanka's health delivery services and environmental sanitation.

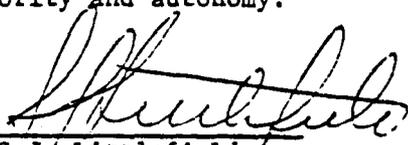
3. The Project Agreement, which may be negotiated and executed by the officer to whom such authority is delegated in accordance with A.I.D. regulations and Delegations of Authority, shall be subject to the following essential terms and covenants and major conditions, together with such other terms and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

a. Source and Origin of goods and services

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

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

- (i) a revised and updated plan for the development of NIHS;
- (ii) evidence that the Cooperating Country has delegated to the Director of NIHS the appropriate authority and autonomy.

Signature: 
 S.J. Littlefield
 Director, USAID/Sri Lanka
 Date: August 29, 1980

Clearances:

AID/C/DSFranklin *sf*

AID/LA/TMuntsinger *mti*

AID/AD/JBrady *JB*

AID:RMSingleton:jf

TERMS AND ABBREVIATIONS

GSL	Government of Sri Lanka
MOH	Ministry of Health
NIHS	National Institute of Health Sciences (Kalutara)
MOH	Medical Office of Health
AMP	Assistant Medical Practitioner
PHI	Public Health Inspector
PEN	Public Health Nurse
FHW	Family Health Worker (formerly Public Health Midwives)
PBM	Public Health Midwives (now called Family Health Worker)
VEW	Volunteer Health Worker

REFERENCES

**A. GSL Project Proposal and Documents Used Extensively
for the Project Paper**

1. June 6, 1980 : MOH Document Regarding Nutting-Salvo Report and Clarifications in NIHS Plan.
2. March, 1980 : "Technical Analysis - The Plan to Expand Facilities and Functions of the National Institute of Health Sciences, Kalutara" by Dr. Paul A. Nutting and Joseph P. Salvo (AID Consultants).
3. April 5, 1979 : Letter from ERD to USAID requesting assistance from NIHS.
4. August 21, 1978 : "Project Request for Development of National Institute of Health Sciences, Kalutara" by Ministry of Health. (Approved by cabinet 11/15/78).

B. Documents Used as Reference or Background Material

5. May 25, 1979 : "Development of Primary Health Care in Sri Lanka - Project Proposals - 1979-83" GSL Ministry of Health.
6. March, 1979 : "A Background Paper on Sri Lanka's Health Sector" by U.S. Department of Health, Education and Welfare.
7. December, 1978 : "Health Manpower Development", UNICEF (UNICEF Planning Document for its \$770,000 Commitment).
8. October, 1978 : "Country Profile Health Sector - Sri Lanka" by Ministry of Health with assistance of WHO.
9. February 2, 1978 : Project Request for W.H.O. for Development of Institute of Hygiene, Kalutara.

PART I. SUMMARY AND RECOMMENDATIONS

A. Recommendations: Grant: \$2,200,000 life-of-project to be approved. \$500,000 to be authorized for obligation in FY 80.

B. Brief Project Description:

Why?

Sri Lanka, like most developing countries, has a serious shortage of medical doctors, which is compounded by most doctors being located in the largest cities. Within the last three years the Government of Sri Lanka has shifted its emphasis from the curative approach to the preventive aspects of health services. Therefore, the GSL is giving increasing importance to the training of paramedics. These are largely rural-oriented primary health care personnel whose training is less than that of the medical doctor: family health worker (FHW), public health inspector (PHI), assistant medical practitioner (AMP) and public health nurse (PHN). They have the skills to bring about: (1) lowered morbidity from preventable diseases through health services and education, (e.g. immunization and oral re-hydration, etc.); (2) lowered birth rates through increased availability of family planning information and services; and (3) lowered malnutrition rates through nutrition education and malnutrition prevention programs. A substantial increase in the numbers of primary health care personnel, accompanied by improvements in their training, is a cost-effective way to improve rural health because such service providers are more quickly and economically trained than medical doctors and they are more likely to live and work in the rural areas.

The need for more and better trained public health workers has become increasingly acute in recent years due to (a) the failure of the health portion of the national budget to keep up with inflation and increased demands for service. (b) continuing migration of Sri Lankan doctors to the Middle East and elsewhere where income opportunities are much greater, and (c) an increasing population which needs health services.

The GSL Medium Term Investment Plan for 1979-83 stated: "The disease pattern in Sri Lanka is characterized by the predominance of preventable diseases. The leading causes of hospitalization, outpatient treatment and death can be traced to the lack of environmental sanitation, especially safe water supplies and sewerage disposal, food hygiene and vector control ... The Health Strategy for 1979-83, therefore places increased emphasis on preventative health care, organizational changes in the curative services and the urgent restoration of the existing health care infrastructure to full operational effectiveness."

The GSL must give more attention to improvement of rural preventive and primary care systems if needed improvements in health, reductions in malnutrition, and desired reductions in family size are to be achieved. Over the years the GSL has established several institutions for training public health workers, but the number of public health workers must be increased by at least 1/3 if the service delivery systems are to be adequately staffed to provide primary health care to the entire population. The GSL has selected the National Institute of Health Sciences at Kalutara (NIHS) to be the leading institution in training more public health workers.

The NIHS was formed in 1926 as the Health Unit and later became known as the Institute of Hygiene. In 1978, WHO/UNICEF assisted in drawing up a plan for transforming the Institute of Hygiene into the NIHS. UNICEF and WHO then indicated a willingness to provide assistance. The plan called for a complete reorganization of the Institute, upgrading of its status within the Ministry of Health, expansion of its physical facilities at Kalutara (about 26 miles south of Colombo), improvements in its curriculum, expansion of the number of people trained annually, and the addition of a program of training for the Assistant Medical Practitioners (AMP). Based on UNICEF's preliminary planning, USAID submitted a PID to AID/W in July, 1979 and received approval for a \$500,000 grant to finance facilities, construction and limited technical assistance. The APAC noted that USAID might consider funding some of the short-falls mentioned in the earlier financial plan.

USAID obtained the assistance of two consultants, Messrs. Nutting and Salvo, to review the planning. The Nutting-Salvo report, March, 1980, revealed that in addition to further organizational changes that were needed, the costs of the program to develop NIHS into a national health training and research institute had been greatly under-estimated. Some of the corrective actions recommended in the Nutting-Salvo report have already been taken and others will be conditions precedent to the AID grant agreement. Cost estimates have been revised and adjusted for the rapid Sri Lankan inflation of the past two years (particularly in the construction field). UNICEF has confirmed the amount of its proposed assistance, WHO has increased the amount of its proposed assistance, and UNDP has joined this multi-donor effort with a commitment to provide \$500,000. As a result of the Nutting-Salvo work and subsequent discussions with all donors and NIHS officials, it became clear that additional money was needed for the construction program. This additional money is to cover both the shortfall from the preliminary, incomplete estimates in the GSL 1978 proposal and the inflationary increase. Since the other donors were providing sufficient funds for the training, technical assistance and a small part of the

building program, USAID became interested in financing the remainder of the construction program, including the architectural/engineering services.

In its expanded role the NIHS will provide many of the trained workers needed for the USAID/GSL Market Town Water Supply project and the GSL Decade of Water and Sanitation Plan in addition to the other needs for public health workers.

What?

AID is cooperating with several other donors in providing assistance for various parts of the effort to transform NIHS into the national training institution for public health workers. Therefore, to distinguish between AID's project and the total NIHS development program, this PP will first describe the overall program and then the AID-financed portion of the program.

NIHS Program: The purpose of the program is to develop NIHS into an institute capable of training increased numbers of public health workers to meet the country's preventive health care needs. When the program is completed, NIHS should be graduating annually about 60 assistant medical practitioners, 50 family health workers, 80 public health inspectors, and 40 public health nurses. It should also be providing several short-term, refresher type courses in all aspects of preventive medical care.

To accomplish the purpose, NIHS needs (a) substantial expansion of physical facilities, (b) scholarships for advanced training of some faculty members, (c) furnishings, equipment, and instructional aids, and (d) technical assistance in the organization, administration and curricula development.

A summary budget and amount of donor contributions for the program is as follows:

<u>Source</u>	<u>Amount</u>	<u>Purpose</u>
UNICEF	\$ 770,000	construction of some facilities, training
UNDP	500,000	training and support costs
WHO	310,000	technical assistance and training
AID	2,200,000	construction of physical facilities, A/E
GSL *	<u>1,220,000</u>	land, some building, furnishings and equipment for facilities
TOTAL	<u>5,000,000</u>	

* NIHS operating costs are not included as part of this program budget estimate.

AID Project: The purpose of the AID project is to finance the construction of most of the physical facilities needed for the program. This includes the auditorium, laboratories, lecture halls, library, seminar rooms, cafeteria, demonstration room and center, utilities and internal roadway. The GSL will provide the land, all furnishings for the buildings, and some equipment. The AID grant will also finance the architectural services for the design of the AID-financed buildings and the supervision of construction for all construction (AID, GSL and UNICEF financed). The financial plan is as follows:

	<u>AID Grant</u>		<u>GSL</u>	<u>TOTAL</u>
	<u>Foreign Exchange</u>	<u>Local Costs</u>		
Construction (AID-financed)	200	430	-	630
Architectual/Supervision	-	173	-	173
Land	-	-	62	62
Buildings (non-AID financed)	-	-	537	537
Furnishings	-	-	280	280
Utilities & Road	-	405	-	405
Landscaping	-	15	-	15
Drainage	-	-	125	125
Evaluation	50	-	-	50
Sub-Total	<u>250</u>	<u>1023</u>	<u>1004</u>	<u>2277</u>
Inflation	60	669	100	829
Contingency	30	168	116	314
TOTAL	<u>340</u>	<u>1860</u>	<u>1220</u>	<u>3420</u>

How?

As a condition precedent to disbursement for construction, NIHS is to prepare a revised and updated plan for the development of NIHS (see page 39 for details). NIHS may need the assistance of an architect consultant experienced in campus planning/design to assist in the revising and updating of the planning done to date in preparation for final design and construction activities. Although the financial plan shown above anticipates only local costs for architectural/engineering (A/E), a limited amount of foreign exchange may be needed for this consultant.

The design and supervision of construction will be done under a GSL host country contract with a Sri Lankan firm. Since UNICEF has a contract with the Sri Lankan firm, Design Associates, Ltd., to prepare the designs for those buildings being financed by UNICEF (hostels), it may be desirable to contract with the same firm for the design and supervision of construction of the AID-financed buildings also, since the buildings will be simple civil structures, and the local design/supervision capability is quite adequate for the task. The construction will be done through GSL contracting with local firms following the GSL bidding/contracting procedures. USAID will make payments directly to the A/E firm and construction contractors.

Evaluation of the project will be carried out with short-term contract and/or TDY assistance. Sri Lankan research organizations may be used to gather base line data and conduct research on progress.

The grant agreement will be signed by the Ambassador and the Secretary of the Ministry of Finance and Planning. Appropriate officials of the NIHS will be named as authorized representatives. A coordinating advisory committee composed of representatives from the several donor organizations and GSL officials will be established to monitor progress of the project and coordinate the efforts of the involved organizations.

C. Summary Findings of the Project Paper: This AID project responds to a specific request for assistance from the GSL and is part of a multi-donor effort to improve primary health services. It is based on the GSL project proposal, UNICEF/WHO planning activities, the Nutting-Salvo report and the subsequent actions of the GSL. The AID contribution must be viewed within the context of the overall program to develop NIHS into a national health training and research center.

A negative determination was made by the AA/ASIA that an environmental assessment would not be needed. Section 611(a) and all other statutory criteria have been satisfied. The Section 611(e) determination is an annex. The officials in the Ministry of Health and NIHS, as well as the donor organizations, are enthusiastic about the program and offer their full support. The project, in summary, is highly desirable, feasible and should be authorized as presented in this PP.

D. Project Issues: The various issues identified by AID/W in its approval of the PID (State 276819, October 23, 1979) have been resolved during project design. Comments on the issues were also sent to AID/W by Colombo 3748 on August 5, 1980.

Project Committee:

GSL: B.C. Perera, Secretary, Ministry of Health
 D. Wijesinghe, Additional Secretary, Ministry
 of Health
 H.A. Jesudason, Director, Health Services
 M.A. Mohamed, External Resources Department,
 Ministry of Finance & Planning
 Godwin Fernando, Director, National Institute
 of Health Sciences
 K.H. Notaney, W. H. O.
 H. Wijemanne, U. N. I. C. E. F.

USAID: James R. Meenan, Capital Development Officer,
 Project Officer
 R.C. Cummings, Anthropologist
 Vitus Fernando, Capital Development Assistant
 Hal Rice, ASIA/TR
 Donald Ferguson, DS/HEA
 Ralph Singleton, Chief, Project Development
 & Support, Editor

PART II. BACKGROUND AND DETAILED PROJECT DESCRIPTION

A. Background

1. General Health Picture and Practices

A formal health care delivery system based on a "Western" system of medicine was introduced into Sri Lanka during the early part of the 19th century. Although this system was not wide spread geographically and served only special groups, nonetheless mortality and morbidity reduction did take place, epidemic diseases abated, and the life expectancy rose during the 45 year period between 1910 and 1946.

After independence, increased demands for improved health facilities and services resulted in expansion of largely curatively oriented facilities in urban areas, and a series of vertical or categorical health interventions. In the mid 1940's the eradication of epidemic yaws was completed. With the introduction of DDT in 1943 and an active spraying and surveillance program, malaria was brought under control, though by no means eradicated. These and other programs resulted in an increase in life expectancy from 30 years in 1930 to 48.3 years in 1950, and to 65.7 years in 1975.

Sri Lanka presently has a Physical Quality of Life Index of 82, which is exceeded only by Korea among AID-assisted Asian countries. However, the use of national statistical averages masks or obscures serious health problems in particular localities and groups. The present government recognizes that many of the health problems have their origin in environmental, sanitary, and nutritional factors, as well as an absence of early detection and treatment services. Consequently, the government is attempting to give greater emphasis to safe water, sanitation, and preventive and primary health services.

Popularly elected governments seldom have a choice between curative or preventive care, and inevitably must provide, or make possible the provision of both. This dilemma is not easily dealt with however, since the demand for curative care will never be lessened unless greater emphasis is placed on preventive interventions and primary care.

As a signatory to the WHO/UNICEF Declaration of Alma, Ata, the Government of Sri Lanka has committed itself to give greater attention to the development of a primary health care program, and vertical programs to reduce and control high

prevalence infections, parasitic, and communicable diseases. The present project seeks to support the GSL in its efforts to expand the numbers and categories of health workers who will carry out these programs.

2. NIHS Role and Evolution

Organized public health activities at Kalutara began functioning through the establishment of the first Health Unit in Sri Lanka as early as 1926. With the assistance of the Rockefeller Foundation, this facility, 26 miles to the south of Colombo, grew and took on responsibilities for field service and training, until today it trains several categories of non-physician providers of health services. Additionally it has conducted continuing education for physicians and nurses in public health in recent years.

In 1966 the Kalutara Health Unit became the Institute of Hygiene and the present classroom facilities were built that year. Somewhat later, hostel space was added to house public health inspector students.

On July 1, 1979, the National Institute of Health Sciences (NIHS) was established by combining into one organization the (a) Institute of Hygiene, (b) field service area of the Kalutara Health Unit, (c) Base Hospital at Kalutara, (d) Rural Hospitals at Aluthgama and Aluthgamweediya, and (e) Central Dispensary of the Police Training College located at Kalutara. This separate, semi-autonomous unit of the Department of Health Services, within the Ministry of Health, then became the only multi-disciplinary, community-oriented, public health training institution in Sri Lanka.

The mission of NIHS, as stated in the August, 1978 MOH proposal for upgrading NIHS, is:

(a) To address itself to all aspects of health manpower development in Sri Lanka (viz. planning, production and management) and to advise the Ministry of Health on policies relating to health manpower development;

(b) To coordinate health manpower development activities in Sri Lanka between the educational and health service agencies;

(c) To initiate and undertake training programs for the members of the Primary Health Care teams with a view to a multidisciplinary team approach to training;

(d) To initiate and undertake continuing education programs for the members of the health team; and

(e) To conduct research and other studies as related to the health services and manpower development.

To carry out its mission, NIHS was given three major functions:

- a. Training: to provide basic, post-basic and continuing education training programs for all categories of health workers for the primary health care team, as well as training for physicians in community medicine and public health;
- b. Service: to the 202,000 people within the 52 square mile area around Kalutara by providing primary health care services, referral to medical care institutions, and public health laboratory services; and
- c. Research: into such subjects as alternative patterns of health care delivery, integrated health care models, behavioral studies regarding basic health problems in the community, appropriate educational technology for training of peripheral workers, and health education.

In addition to the above, a major new teaching responsibility added to the NIHS is a three-year training program for assistant medical practitioners (AMPs). Three medical schools under the Ministry of Higher Education are the only sources of AMPs at present. The AMP program was developed to reduce problems associated with recruiting and retaining physicians as health providers in rural areas. The problem of emigration of physicians is a continuing one, and is unlikely to change substantially during the next decade.

The MOH proposal of August, 1978 called for the expansion of the NIHS to occur in two phases. Phase I, which was planned for calendar years 1979-80, includes the following:

- a) Designation of the Institute as the National Institute of Health Sciences.
- b) Construction of additional facilities at the NIHS and the Base Hospital at Kalutara.
- c) Increase in the NIHS staff.
- d) Development of new curricula for the PHI, PHN, and FHW emphasizing a multi-disciplinary team approach to primary health care.
- e) Development of a new curriculum for the AMP.
- d) Development of courses for mid-level managers in the Department of Health Services.
- e) Initiation of AMP training.

- h) Construction of four primary health care centers for testing new primary health care models.
- i) Development of an audiovisual training capability; and
- j) Development of a research capability and conducting research.

Phase II is to occur during calendar years 1981-83 and includes the following:

- a) Designation of the Director of the NIHS as the Deputy Director for Health Manpower Development within the Ministry of Health;
- b) Development of a health planning and management unit within the NIHS, which will work with the Planning Unit of the Ministry of Health on health manpower development;
- c) Continuation of staff development for the expanded functions of NIHS;
- d) Implementation of the curricula developed in Phase I for the PHI, PHN, and FHW which stress a multi-disciplinary approach to primary health care; and
- e) Initiation of the course in community health management for mid-level managers.

The Cabinet approved the plan; the consolidation of units into the NIHS has taken place; work has begun on redesign of the PHI and PHN curricula; WHO, UNICEF and UNDP have committed support and an amended schedule of target dates for elements of each component has been drafted. Priority attention must now be given to staff recruitment and expansion of facilities to meet the expanded numbers of trainees. Some activities of Phase I as well as Phase II will be completed, with donor assistance, over the next 3-4 years. It will also be necessary to update the NIHS plan to reflect events of the last two years. When fully developed the NIHS will function as the national center for health manpower planning and development; health management training, and applied research in community health and primary health care.

3. Evolution of the Project

The MOH recognized that to carry out its new responsibilities, the NIHS needed to expand its physical facilities, enlarge its faculty, and modernize its curriculum. On April 5, 1979, the GSL submitted to USAID a formal request for assistance based on the August, 1978 proposal. UNICEF and WHO had already responded to requests for assistance. In July 1979, USAID sub-

mitted a PID for a \$500,000 grant to finance facilities, including an auditorium, library, lecture or class rooms and a small amount of technical assistance. APAC approved the PID on September 28, 1979 with a suggestion that if sufficient funds were not obtained elsewhere for the project shortfall in overall funds, USAID should consider providing additional funds (State 276819).

Following a more detailed analysis of needs by AID consultants Nutting and Salvo in April, 1980 and after discussions with other donors and the GSL, it became apparent that a different arrangement of instructional rooms and associated physical facilities was required. It also became apparent that the 1978 planning cost estimates were far too low. These factors, plus recent inflation rates of 45-50% in the construction field, made it evident that if AID participated at the level originally contemplated (\$500,000), there would be a serious funding shortfall which would endanger the planned expansion of primary health services in Sri Lanka. After serious consideration of alternative options, USAID decided to request the additional funding required for its contribution to this multidonor effort to develop the NIHS. As planned, WHO, UNICEF, and UNDP will finance technical and managerial assistance, some equipment, and training. UNICEF will also finance the construction of student hostels and model health center facilities. This division of labor among donors should also reduce the amount of direct staff time which USAID will have to devote to project monitoring and implementation.

B. The Program for NIHS Development

As stated above, AID assistance is only one of several inputs into the GSL plan to develop the NIHS. To avoid confusion we will use the word program to mean the total NIHS development activity (inputs from all donors and GSL) and the word project to mean the AID financed part of the program. After briefly describing the NIHS program below, the description and analyses thereafter in this PP will concern only the AID project; i.e., the buildings, related utilities and A/E services to be financed by AID. For this reason, two logical frameworks are included in the annex: one for the overall program and one for the AID project.

1. Program Goal: The goal is to enhance human productivity and well-being by improving community health.

2. Program Purpose: The purpose is to increase the capacity of the NIHS to train the quantity and quality of health care workers required to support the GSL programs to improve health delivery services and environmental sanitation. At the end of the project, NIHS should be training annually about 60 AMPs, 80 PHIs, 50 FWHs, and 40 PHNs. The NIHS should be designing and testing new health delivery models.

3. Program Outputs: The outputs include the construction of physical facilities at Kalutara, the staff expanded and the curriculum revised and installed.

4. Program Inputs: To achieve the outputs, the following financial inputs will be provided:

AID	-	\$2,200,000	for construction and A/E services.
UNICEF	-	770,000	for construction, scholarships and technical assistance.
UNDP	-	500,000	for training and other support costs.
WHO	-	310,000	for training and technical assistance.
GSL	-	1,220,000	for construction, land, and furnishings.
		Total	5,000,000

Note: Details of the WHO and UNICEF activities may be found in their project papers. The GSL contributions do not include operating costs.

C. The AID Project

1. Goal: The goal of both the NIHS program and the AID project is to enhance productivity and human well-being through expansion of primary health care for all people in Sri Lanka.

2. Purpose: The purpose of AID assistance is to support that part of the NIHS program involving the expansion of physical facilities at the NIHS program needed to train more public health workers and do related research for all levels of the paramedical system.

The End-of-Project Status will be the facilities completed, fully equipped and used for teaching and research.

The key assumptions include: (a) the GSL will provide the furnishings for the buildings and (b) the NIHS will be able to retain its teaching and research staff.

There is a definite linkage between the project purpose and goal in that the NIHS would be able to train more and better qualified people to provide primary health care to the public throughout Sri Lanka if it has the facilities (and staff).

3. Outputs: The outputs of the AID project are the following equipped buildings and related utilities:

	<u>Estimated Size</u> <u>(square feet)</u>
Auditorium	5,000
Library (including rooms for documentations, administration, staff and rest rooms)	3,500

Six lecture halls	4,200 (total)
Two seminar rooms	2,000 (total)
Audio-visual laboratory	1,000
Demonstration center	2,000
Demonstration room	1,000
Six lab rooms	4,200 (total)
Cafeteria	1,500
Utilities	-
Interior road	-

Inputs:

AID: The grant of \$2,200,000 life-of-project will finance the construction of the buildings (including the equipment that is an integral part of the buildings such as lighting, wiring, etc.), utilities, site preparation, interior road, design work and construction monitoring, (i.e. Architectural/Engineering Services - A/E).

GSL: The GSL will provide the land (10 acres were bought in 1979 for this expansion program), furnishings and some equipment for the buildings, landscaping, construction of three small buildings at NIHS site (director's bungalow, garages, and first aid/warehouse building) and some buildings constructed elsewhere which are needed for the research and local health care functions. The estimated value of these inputs is \$1,220,000. Operating costs and in-kind contributions (such as buildings already in existence prior to the time the expansion plan was prepared) have not been included as inputs here or in the financial analysis. The annual operating expenses of NIHS are about \$400,000.

The key assumption is that the GSL and AID will provide the indicated amount of funds as needed to finance the outputs. The analysis during the project design which is described elsewhere indicates that the stated amounts of inputs should be sufficient to achieve the outputs.

PART III. PROJECT ANALYSIS

A. Technical Analysis

1. Sri Lankan Profile

a. General: The island of Sri Lanka covers 25,332 square miles and its estimated population in 1980 is 15 million. As an agro-based economy, 80% of the population is dispersed in rural areas and is clustered in more than 22,000 villages, a circumstance which must be taken into careful account in the development of primary health care services. Additional general information on Sri Lanka may be found in the 1980 CDSS, and will not be repeated in this paper. Health, population and nutrition information germane to this project will be elaborated in sections to follow.

b. Population/Health Profile: Both fertility and mortality in Sri Lanka have shown appreciable declines since 1945; however, the decline in death rate has been more impressive. The crude death rate fell from 21 per 1,000 in 1945 to 14 in 1947 and then to 6.5 in 1971. Corresponding figures for the crude birth rate are 35.9, 38.6, and 27.9 respectively. There was a slight increase in fertility in 1978, at which time the crude birth rate was 28.4.

A marked decline in mortality is generally attributed to the control of malaria by the DDT spraying campaign initiated in 1946. Further and more gradual declines in mortality have been attributed to improved medical care, improvements in environmental sanitation, free feeding of school children and general improvements in standard of living.

The decline in the birth rate is attributable to two factors: a rise in the average age at marriage of females and a reduction in marital fertility, possibly due to the use of contraception on the part of married couples. For the period of 1963-1971, changes in marital fertility were responsible for 40% of the decline in the birth rate and the remaining 60% was due to changes in marital composition. It seems quite likely that the recent rise in fertility is attributable to an increase in nuptiality rates on the part of women of marriageable age, particularly younger women.

The population of Sri Lanka grew relatively slowly until 1953 when the population growth rate reached 2.8 percent, the highest rate ever recorded. The rate of population growth has declined steadily since that time reaching 2.2 percent in 1971. The increase in population due to migration exceeded the rate of natural increase during the intercensus periods of 1871-1881 and 1891-1901. The contribution of immigration to population growth has declined steadily since the turn of the century however, and since 1953 international migration patterns have resulted in the net loss of population.

The result of relatively high fertility until rather recently and of quite low mortality rates has been a "young population" with 39 percent of the population under the age of 15 years in 1971, as compared to 30 percent or less in many developed countries. On the other hand, those aged 65 years or older constituted only 4.2 percent of the population while in the developed countries people in this age group may account for 10 percent of the total population.

c. General Epidemiological Patterns: Morbidity and mortality patterns reflect primarily the influence of an adverse physical environment and to some degree the so-called diseases of civilization. The latter is especially true of mortality rates.

Leading causes of morbidity, 1976 (rates per 100,000 population):

1. Malaria	2,217.7
2. Diseases of the respiratory system, pneumonia, bronchitis, etc.	2,321.4
3. Delivery without complications	1,798.0
4. Accidents, poisoning, and violence including homicide and suicide	1,682.9
5. Diarrhea, including cholera, bacillary dysentery, amebiasis, etc.	1,297.6
6. Complications of pregnancy, including abortions	964.5
7. Diseases of the digestive tract, peptic ulcer, gastritis, etc.	828.1
8. Diseases of the skin	758.2
9. Diseases of the genito-urinary system	615.9
10. Diseases of the circulatory system, ischemic heart disease, stroke, etc.	576.6

Leading causes of mortality, 1976 (rates per 100,000):

1. Diseases of the circulatory system	84.07
2. Diseases of the respiratory system	70.04
3. Accidents, poisoning and violence	63.12
4. Diarrhea diseases	53.64

5. Diseases of infancy, birth injuries, prematurity, etc.	47.30
6. Neoplasms	30.77
7. Nutritional deficiencies	22.77
8. Anemia	21.80
9. Tuberculosis	11.60
10. Diabetes Mellitus	9.51

It is noteworthy that seven of the ten leading causes of death are preventable to a greater or lesser degree. Indeed, it is entirely possible that some diseases not identified as preventable in this analysis, namely, certain diseases of the circulatory system and neoplasms etiologically related to the use of betel and tobacco may be preventable as well.

d. Nutrition: Nutrition has been singled out for separate discussion because GSL has had significant influence over many years on the food distribution system first through subsidized food rations and since 1979 through a food stamp program.

In the early 1970's severe undernutrition was reportedly the second highest cause of death in Colombo hospitals, but since the late 1970's is uncommon. Surveys in the late 1960's and early 1970's highlighted widespread malnutrition ranging from 66% to 83% of the children surveyed. The most comprehensive information derives from the 1975 survey undertaken by the Ministry of Health with technical assistance from the Center for Disease Control, U.S. DHEW, in which 13,450 children 6-70 mo. of age were examined and were selected on a proportionate district population sampling basis. The combined prevalence of second and third degree malnutrition ranged from 38.9% in villages to 63.8% among estate children. This difference between the values for the estates and the villages is statistically highly significant. Existing data indicate that the nutritional situation of the most vulnerable population groups has not improved markedly over the last decade, despite moderate increases in income levels. Moreover, there are indications that the situation may in fact be deteriorating among the poorest segments of the population in both rural and urban areas.

Poor maternal nutrition, expressed in below standard height and weight, is the primary cause of low birth-weight infants. It is these infants who, in turn, are more vulnerable to undernutrition than those of well-nourished mothers. Some 20% of the babies born at De Soysa Maternity Hospital were of low birth weight. Of these, only 20% were premature births while 80% were small despite being full-term deliveries. The extent of maternal

malnutrition is strikingly demonstrated by the fact that 38% of women gain less than 4.5 kilos during their pregnancy, and 24% of all pregnant women give birth to infants weighing less than 2.5 kilos. An estimated 250,000 pregnant and lactating women need iron fortification and over 80,000 are severely anemic.

One of the main objectives of the national supplementary feeding program has been to improve the weight of mothers as a preventive measure for reducing the incidence of low birth weight. Age at marriage also was related to birth weight with the lowest weights occurring in young mothers under 20 years of age.

Income levels are an important determinant of diet adequacy. There has been a significant reduction in intake of both proteins and calories for all income groups during recent years. The 1969/1970 socio-economic survey indicated that 43% of the population was comprised of individuals earning less than Rs.200 per month who did not meet the recommended daily allowances (RDAs) for Sri Lanka for either calories or proteins and who were spending approximately 63% of the total average monthly household incomes on food. In contrast, the highest household income groups consumed 441 calories and 18 grams of protein above RDAs, but these groups used only 33% of their total monthly expenditure for food.

By 1973, average per capita consumption of calories and proteins had fallen from 103% to 88% of RDA of calories and from 112% to 92% of protein. Only the top 4.5% of the population, by income, were meeting the RDAs.

In order to track the trends of malnutrition a regular surveillance procedure is necessary which includes anthropometric data, food availability and prices, and health indicators such as diarrheal prevalence, hookworm, measles, tuberculosis and other nutritionally interactive disease entities. Even more important from the point of view of immediate health interventions by health workers is the establishment of a continuous weight progress record by month on each child at risk.

Close followup of the growth progress of the young children at risk is particularly important in view of GSL nutrition intervention programs now active such as food stamp program, the thriposha program and various other food distribution programs under consideration (milk, soya, wheat/soya).

2. Health Delivery System Profile

a. Institutional Overview: There is a fairly extensive network of traditional and modern health service outlets in Sri Lanka. The 1969-70 Socio-Economic Survey which is the latest available, provides a good overview of the health delivery system. About 73% of the demand for medical services was met through the

Western system and 22% was met through indigenous (primarily Ayurvedic) systems. The government sector accounts for 54% of the demand and the private sector accounts for about 42%. Tables I and II in Annex E. provide breakdown types of institutions and categories of health workers by sector (public versus private) and by type of medical system.

The institutional pyramid for public health services is topped by teaching and provincial hospitals (600 + beds) in cities, broadens to small rural hospitals (20 beds) and has central dispensaries (small outpatient units) at the base. The quality and quantity of facilities and staffing generally decrease as you descend the institutional hierarchy.

The Ministry of Health has over 42,000 employees, making it the second largest ministry in Sri Lanka. Public health care in Sri Lanka continues to be free although supply shortages may require the client to buy his own medicine. There are also private pay-wards in some government hospitals for those able and willing to spend more for better facilities. Although the patterns are not uniform, there is generally overcrowding of the larger hospitals and under-utilization on the lower level service outlets. A major reason for this is the desire of clients to have access to a fuller range of services, particularly in the event of medical complications. The lack of basic communication and transportation services (especially ambulances) is also a reason for the absence of orderly client referrals from lower to higher levels of the service delivery system. Of course, in many rural areas understaffed and undersupported lower level care units mean that few services are actually available at that level.

Sri Lankan officials make clear organizational distinctions between curative and preventive functions and between Western and traditional practitioners. The responsibility for preventive functions is assigned to the medical officers of health (M.O.H.) who, in turn, supervise assistant medical practitioners (AMP), public health nurses (PHN), public health inspectors (PHI) and family health workers (FHW) as the primary health outreach workers. Within traditional medicine, there are also distinctive categories according to basic diagnostic strategy (Ayurvedic, Siddha, Unani, etc.), specialization or sub-specialization, and family or communal heritage. It is common Sri Lankan practice to refer to all traditional practitioners as ayurvedics. There does not appear to be very close cooperation among western and ayurvedic medical practitioners although the idea of more active involvement by traditional healers in the public health system is discussed from time to time. Resistance to integration comes from both sides.

While the stated GSL goal is to achieve a ratio of one Government doctor (Western) per 3,000 population, in 1978 the actual ratio in the Superintendent of Health Divisions (districts) ranged from 8,850 (Kandy) to 20,360 (Matara) and 51,560 (Colombo). The total number of government doctors was 2,229 or a national ratio of 1/6,280. During the first ten years after doctors are registered, 41% cease practicing medicine in Sri Lanka for various reasons (especially emigration). The loss rate for nurses and midwives is estimated at only 3% while it is about 8% for registered ayurvedic practitioners. The GSL has decided to increase the numbers trained in all these categories of health workers. In addition to serious staff shortages, there is a need to restructure the primary health delivery system and change both types and levels of responsibilities assigned to various non-physician as well as physician health providers.

b. GSL Plans to Improve Health Delivery: To achieve improved health care delivery under serious budgetary constraints, the present government recognizes the need to shift from the present heavily curative and hospital oriented health system to a more preventive and peripherally focussed integrated delivery system. Some evidence for a shift in emphasis can be seen in recent statements expressing the GSL's growing concern about population growth and payment of service fees for sterilization; the high priority being given to provision of safe water during the coming decade; the continuing extensive, although reduced food subsidy given through a better targetted food stamp program, and renewed attention being given to primary health care delivery, to which this project will make an important contribution.

(i) Health Development Trends in Sri Lanka

As a result of a recent Government review it was decided to introduce changes in the health system, especially with respect to manpower development and utilization in the following areas: (a) Placing greater emphasis on the preventive aspects of health services; (b) Developing an integrated community oriented health care system; (c) Directing specific attention to the community and village level in order to obtain more satisfactory approaches to the health problem.

The new approach in government policy has been expressed officially in a number of ways. The policy statement on health services in the Government's manifesto of July, 1977 states "great emphasis will be placed on preventive medicine by instituting programs encompassing health education and by initiating community health projects as well as establishment of auxilliary health aides".

The Medium Term Investment Plan 1979-83 put out in February 1979 states:

"225. The disease pattern in Sri Lanka is characterized by the predominance of preventable diseases. The leading causes of hospitalization, outdoor treatment and death can be traced to the lack of environmental sanitation, especially safe water supplies and sewerage disposal, food hygiene and vector control. Resurgent malaria is a serious problem in the dry zone and the incidence of venereal diseases anaemia and malnutrition has doubled over the last decade.

226. The health strategy for 1979-83, therefore, places increased emphasis on preventative health care, organizational changes in the curative services and the urgent restoration of the existing health care infrastructure to full operational effectiveness".

At the base of this new approach is strengthening the middle to lower level health worker cadre such as the ANP's, FHW's, PHI's and other health auxiliaries. Training has been revised for these categories but much more revision is required. For example, the FHW's and PHI's need to be trained to provide immunization and delivery of basic health care.

In the context of rapid development of the country and the expressed changes to be initiated in the health system to bring better health to the population, the Health Department must train more and more middle and lower level workers and provide community and field oriented training to medical officers and staff who are required to play a different role in a new integrated primary health care system.

(ii) Magnitude of the Training Program Required to Carry-out the Health Policy: It is obvious that the new policy calls for an increase in the manpower needs for all categories of health workers. This need is clearly identified in section 231 of the medium-term investment plan which states: "Manpower shortages seem likely to arise at almost all levels of the health service, so that a major development and expansion of training facilities and intake, particularly of doctors, nurses, assistant medical practitioners, public health workers and community health workers will be necessary."

If progress is to be made in providing health service personnel required to carry out this stated policy a training program and institutional base needs to be established on a priority schedule. Two priorities which emerge in regard to manpower needs are: (1) a planned program of training over a specific period of time for required personnel and (2) changes in the present training programs as well as initiation of new training programs in order to meet new needs.

3. The Health Delivery Problem:

The shortage of trained and rural oriented primary health care personnel in Sri Lanka is a key problem. The tradition of free medical care has been largely hospital and curatively oriented. The loss of professional medical workers through emigration and erosion of system capacity from declining budgets further adds to problems in the health sector. Unless remedied, deterioration in health conditions can also be expected to accelerate as inflation and the increasing price of energy affect the poor disproportionately. Furthermore, in rural areas, where most of the poor live, the health system is least equipped and staffed to serve health needs.

Of the doctors graduated during the 1960's, about 60% found opportunities abroad during the 1970's to be more attractive than in Sri Lanka and migrated. Earlier government policies to promote equity by placing ceilings on physician income stimulated this professional brain drain, and probably affected rural areas disproportionately. Appropriations for health facilities, which have traditionally favored urban areas, simultaneously declined and income from private practice, which strongly induces professionals to locate in urban areas, became an even stronger incentive to locate or relocate to populous, relatively affluent towns and cities. Thus, the present government is faced with a need to both rehabilitate and redirect the health system at the same time it is trying to find resources to initiate new programs in other sectors. The magnitude of the task can be seen by noting declines in budgets for social services in Table III of Annex E.

At a time when GSL has found it necessary to shift its priorities away from social welfare programs towards more economic development and employment generation activities, its policy statements, nonetheless continue to stress the need to expand basic health services. The picture is not entirely bleak however. Much opportunity for improvement in basic health services exists even at present budget levels if the balance between curative and preventive services can be shifted. Hospitals and curative services absorb roughly 70% of available funds while preventive services account for about 20%; and administrative services the balance. The MOH itself delivers about 60% of the total health services and the private medical sector 40%. In addition, expenditures for other health related programs such as food subsidies and domestic water and sanitation equal the MOH budget.

4. The Need for the National Institute of Health Sciences

The effective expansion of the public primary health care system is dependent upon the recruitment and development of additional manpower and the improvement of the delivery system based on testing of alternative models. Because of the strong emphasis on curative care in Sri Lanka, medical schools and hospitals are considered less suitable as the key institutions to undertake expansion of the

primary care system. Kalutara is the one major institution that has been basically oriented towards training of non-physician health providers. Therefore, the GSL has decided to utilize this experience to upgrade the Institute, enlarge its role, and expand its output not only in number of workers trained but by having the NIHS do operational research and test new models of integrated health care.

AID consultants (Nutting and Salvo) reviewed the plans to expand the staff and facilities and recommended changes, all of which have been accepted by the MOH. Furthermore, the MOH has accepted recommendations concerning specific ways to increase the autonomy of the Institute in such areas as scheduling of numbers of trainees, timing of training programs, and strengthening institute administration, facilities management and maintenance. Important to attaining autonomy is the plan to create the position of Deputy Director, Health Manpower Development in the Directorate of Health Services to be held by the Director of the National Institute of Health Sciences.

The data of Table IV in Annex E shows the number of trainees currently at the NIHS (computed as an average over the last five years), the total numbers trained annually in Sri Lanka, and the same figures projected to 1983. The data suggests that by 1983 the NIHS will be training 39% of all manpower for the primary health care team, and will have increased its training output by approximately 107%.

The data in Table IV (Annex E) estimates the current deficit in staff for each of the primary care disciplines, and projects the deficit to 1988 (five years after the NIHS has been in full operation). Although some of this data is outdated, it nonetheless serves as a reasonable estimate of the extent to which the NIHS can close the gap between health care staff available and manpower required. Based on estimates of current need and current level of staffing, the estimated annual loss of manpower through attrition, the increased need for personnel due to growth of the population, and manpower trained each year, it is projected that current deficits in manpower will be reduced by 46% (PHI), 90% (PHM), 62% and 83% (AMP). That is to say, the NIHS expands its training output as proposed, the percent of the health manpower need currently being met and assuming planned outputs by NIHS by 1988 is shown below:

Percent Health Manpower Needs Met by Category of Worker

	<u>1980</u>	<u>1988</u>
PHI	77%	90%
PHW	56%	96%
PHN	49%	84%
AMP	50%	92%

The NIHS expanded program will begin in October 1980 with the introduction of the assistant medical practitioner (AMP) curriculum to produce about 60 AMP graduates per year. This is a major step forward for NIHS since the AMP is the senior-most level in the paramedical hierarchy. The AMP curriculum is 2-½ years in length. Since the AMP is to be specifically trained to provide services and function as coordinators of multi-disciplinary primary health care teams, major modifications must be made in the current curriculum to include training in multi-disciplinary settings with a substantial amount of supervised field work. Presently, NIHS trains all other levels in the primary care system: public health inspectors (1 yr.); public health nurses (6 mo); and family health workers (3 mo). Furthermore, NIHS offers refresher and continuing education courses for all levels in the system. Some of the need for new facilities can be attributed to the new AMP program since more highly qualified and increased numbers of faculty, more sophisticated teaching laboratories, more long-term hostels and lecture halls, and equipment and more administrative capacity will be required.

The next step in NIHS development will come when the second class of AMPs arrives in October 1981 at which time additional faculty and teaching facilities must be available. The plan calls for equipping and using existing buildings for the AMP program until new buildings are complete. The training schedules for short courses and continuing education will be altered in order to accommodate the AMPs during the construction phase. The GSL feels obliged to move rapidly to expand primary health care manpower even though NIHS facilities may presently be less than ideal. By the end of the second year NIHS expects to have newly designed curricula which inter-relate tasks of the worker teams. By the time the third class of AMPs enters in October 1982, much of the construction should be complete and the strain on facilities should ease. Priorities in the construction will be set by the early need for teaching, laboratory and hostel facilities.

The NIHS is currently developing course material for a continuing education module for training physicians and senior AMPs as middle managers in management of the health care system. Although no definite projections of the number of trainees envisioned per year are available, the development of such a course will result in a substantial qualitative increase in the training output of the NIHS. To achieve these outputs the staff required at NIHS is to be expanded as shown in Table V of Annex E.

The consultant's analysis of space required for proposed training levels concluded that space utilization levels would be satisfactory (about 20% for lecture and seminar space) except for laboratories (64%). Since the curriculum is being revised, and may call for fewer laboratory courses, the Institute has decided

not to expand laboratory space at this time. Table VI (Annex E) show space requirements and training capacity. Plan of the existing and projected facilities is appended as Annex F.

NIHS development requires a broad range of inputs: construction of teaching facilities, staff quarters, and hostels; site development; laboratory and visual aids equipment; teaching materials and supplies; vehicles; furniture; utilities expansion; additional staff; staff upgrading; new curricula; revised curricula; operational research development; and development of teaching facilities in service areas (nearby hospitals and health centers).

Other donors already committed are UNICEF, UNDP and WHO. UNICEF will construct dormitories, and provide technical assistance materials and equipment for teaching, laboratory and visual aids. WHO will provide visiting professors and staff upgrading, UNDP will provide technical assistance, training, equipment, consultants for curriculum development and operational research development. The GSL will provide site improvement, furnishing, staff quarters construction, supplies and base hospital teaching services.

B. Economic Analysis

A definitive cost-benefit analysis is difficult to conduct in health sector projects even under the best of circumstances and would be impossible for this project since AID is financing only a portion of the program. Therefore, the economic analysis is limited to a discussion of cost or feasibility of alternate approaches and to the return on research.

Although there is a lack of solid evidence, it is generally assumed that cost-benefit ratios associated with preventive activities are superior to those associated with curative activities. For this reason the primary outputs of this project are an enhanced ability of the health care system to implement and coordinate preventive and public health services. According to morbidity and mortality statistics recently presented by the Ministry of Health, approximately 200,775 (19.5%) of the inpatient cases treated in the Government hospitals were due to preventable illness, and 3,969 (12.3%) of institutional deaths in 1975 were also due to diseases which are within the state-of-the-art of health care to prevent.

An alternative to developing the capability for training AMPs at NIHS would be to increase the capacity for training AMPs by the three institutions currently providing AMP training, i.e., the University of Colombo, the University of Peradeniya and the Jaffna University. However, training programs at universities are under the administrative control of the Ministry of Higher Education. The Ministry of Health wishes not only to increase the output of AMPs but more importantly to produce a different kind of AMP -- one oriented to a more balanced view of curative and preventive services, oriented to a community-based view of health care, and trained to be an effective coordinator of the primary health care team. The Ministry of Health feels that in order to develop this curriculum for the AMP, training must be under the control of the Ministry of Health.

The cost benefit ratio to train the AMP would appear to be favorable since the cost of training is approximately 40% that of training a physician and training time is considerably shorter. Furthermore, funds spent for training are less likely to be wasted, since, unlike physicians, AMPs are not licensed and cannot easily find positions using their training outside Sri Lanka.

The research capability of the NIHS potentially can have a tremendous effect on the cost benefit ratio of the project. If research issues are appropriately identified and prioritized, and if knowledge deriving from studies is effectively fed into future policy, planning, and development activities of the Ministry of Health, a relatively modest investment in health service research can pay tremendous dividends in terms of the health of the beneficiary population. Many important studies will be relatively inexpensive, can be conducted by students and may be easily incorporated into the NIHS training programs. This is already been done at the NIHS where, for example, an excellent study of the state of the communities' knowledge of helminth infestation was undertaken by a class of public health inspectors as part of their training. The results of this study have been used to restructure more effective health education approaches and material.

Although particularly difficult to quantify, the rural community should benefit from a health care system which integrates both curative and preventive health services at the local level since this will increase the opportunity to receive both preventive and curative services at one site.

C. Social Soundness Analysis

The expansion of the facilities and functions of the NIHS per se will not have substantial social implications. The important social implications come into focus only by viewing the NIHS role in the broader context of the schemes of rural health care that are evolving in Sri Lanka. Although the many descriptions of this continually evolving model or scheme will differ, it is approximately as described here.

Essentially, the model consists of three tiers. At the bottom or village level would be the primary level team composed of the public health inspector and family health worker (formerly called public health midwife) supplemented at the township by Ayurvedic doctors and at the village level by volunteer village health workers (called community health workers in Nutting-Salvo Report). At the next level would be the integrated health center (IHC). Each IHC would be staffed by an assistant medical practitioner, public health nurses, and an Ayurvedic or western doctor and would be responsible for several primary level teams. At the third level would be the regional hospital, under a regional medical officer, who would be responsible for the planning, implementation, monitoring, and evaluation of work in his health regional. This analysis is mainly about the first and second levels of the model.

Since the country's approach to rural health care is still evolving, one of the important functions of NIHS is to develop and test different approaches and aspects to rural health care. Thus, in addition to training of public health people, NIHS has an important role to play in rural health care through its research and testing function.

1. Beneficiaries: Each primary level team is expected to serve about 10,000 people, and each IHC to serve about 30,000 people. Under the four year life of this project, the people directly trained by the NIHS will serve about 3.5 million potential beneficiaries. When this system is fully operating in 1988, approximately 8.0 million additional people will be served.

A final point in regard to beneficiaries relates to the pattern of morbidity and mortality in Sri Lanka, i.e., that 45-50 percent of the leading disease and health problems and 7 of the 10 leading causes of death are preventable. Since morbidity and mortality

rates of the poor are proportionately higher than other groups, the project's emphasis on preventive health care and early intervention should have a proportionately greater impact on lower socio-economic groups.

2. Social Feasibility: Several noteworthy features of this evolving model ensure its social feasibility. First, the services of indigenous health workers would be utilized. These practitioners are currently serving an estimated 30 percent of out-patients in the country. These indigenous health personnel, have the confidence and respect of local people with whom they live and work. To the extent that ayurvedic health workers can be trained and incorporated into the system to provide preventive health care, the task of getting rural villagers to adopt preventive health practices will be greatly facilitated. The difficulty of this task will be considerable given the diversity of assumptions made concerning illness causation by different traditional practitioner groups.

A second important feature is the concept of village health worker (VHW) as a link with the FHW. The volunteer selected for this position by the villagers will be given special training by instructors who have been given training by the Health Education Bureau, the Regional SHS staff or by NIHS. The VHW, as a member of the primary health care team, will work to mobilize community support for health services and practices and will provide health education motivation and referral services. Pilot VHW efforts begun in the early 1970s have spread to all regions of the country. By 1977, some 436 VHW programs were in operation in Sri Lanka.

Besides being trained to recognize several health conditions and to refer to appropriate members of the primary health care team, the VHW is to be the vehicle through which the primary health care team will receive important information relating to the health needs of the community. In this regard, the VHW will conduct investigations relating to simple health problems of the community. In this innovative way, the community itself will participate significantly in formulating their own health care programs.

A third feasibility feature of the project is the prominent position given to the NIHS's research activities. The health research unit will be responsible for conducting studies which, among other things, examine: (1) the prevalent patterns of health-related behavior in the community; (2) community-level health needs, particularly in regard to preventive health care; (3) alternative methods of health delivery (especially better methods of integrating indigenous health practitioners into the system); and (4) the best means of educating villagers regarding preventive health practices.

The research unit will also undertake evaluation of the system's impact and the training program's effectiveness. This research will allow the NIHS to alter and modify training programs to meet the needs of both trainees and those served, ensuring that the system is both effective and relevant to the rural health care situation.

One problematic aspect of the project's feasibility which will require monitoring by the NIHS's research unit is the acceptability of certain new practices commonly associated with preventive health care in the rural areas. These include boiling water, latrine construction, food preparation and storage, and certain nutritional/dietary practices. Acceptance by the rural people of these new practices will be easier if they don't require much money or labor from the people. For the most part, however, these health practices do require additional costs. For example, boiling water requires more firewood, and latrine construction requires money for laborers, masons, and materials. Such costs are often beyond the means of poor villagers. The research unit needs to analyze these problems of acceptability related to socio-economic status and to recommend alternative practices which are effective though less costly. The research unit may also recommend additional interventions which ease these financial constraints (e.g., provision of credit or material subsidies) and facilitate acceptance.

3. Spread Effects: The entire project design is premised upon a spread effect, namely that health cadres can be trained and placed (in some cases replaced) in rural areas to provide basic health education and preventive care. To the extent that these persons can be effectively trained and motivated to fulfill their proposed duties and functions, the entire community which the health worker serves stands to benefit in improved environmental, family, and personal health status.

There is also a generational spread effect inherent within the project's design. Most of the emphasis is on education, particularly related to environmental health and preventive care. This educational effort is directed primarily to the household, with women as primary recipients. To the extent that these health instructions are accepted and implemented within households there is a high probability these instructions will become part of general knowledge handed down to children. These children, having learned environmental health and preventive care information from their mothers, will more likely adopt these same practices and techniques when they are adults. At the very least, these children will be more receptive to additional health education (e.g., from the school, temple, and community leaders) if they have also received primary exposure to such instruction in the home.

A final spread effect, though difficult to quantify, is the more general benefit that accompanies good health, i.e. the physical and mental well-being that allows people to engage in productive activities, to maintain a household and/or raise a family, to participate in community, religious, and other social activities, and to enjoy the benefits of one's leisure. Health benefits reverberate throughout a society.

4. Social Impact: In Sri Lanka, as in other developing countries, the upper socio-economic classes are better educated and have greater knowledge of preventative health care and practices. They also have more money and other resources (e.g., personal contacts) to avail themselves of better curative care. Their general health status, therefore, is usually much higher than that of lower socio-economic groups. Though not designed specifically to benefit lower socio-economic groups, the health care and instruction under this project, aimed as it is toward preventive care and referral services, will likely have a greater impact upon lower socio-economic groups. This is not to say that the upper socio-economic groups will be precluded from receiving project benefits, but rather this group will have less need to use these services.

On the other hand, it is expected that the better educated, somewhat better off villagers will become the village volunteers, since these people are often more motivated towards community service and have more leisure to do so. The support of these people will also be critical in undertaking activities related to environmental health.

5. Women in Development: Women are the major beneficiaries of this project, both in terms of training provided and services received at the community level. Women have traditionally played an important role in the maintenance of family health in Sri Lanka and this role is maintained in the development of the primary health care model. For example, most of the instruction about food preparation and nutrition, sanitation and general hygiene will be directed toward the household and thus primarily toward women.

Women will be the exclusive trainees of the PHN and FHW programs and they will likely occupy at least one-third of the AMP positions. Community-based health programs which place trained female health workers in the rural areas generate greater benefits for women in general than do programs where the local-level health workers are males. Female nurses at the IHCs will also facilitate rural women's access to health services and care.

Family planning is also an important component of the total health package being delivered to rural communities. Since family planning decisions are often made by the men, the PHI (who is generally a male) will focus on men while the FHW (a female) will focus on the women. This two-pronged approach is likely to be more effective than traditional efforts to introduce family planning practices which focus mainly on women. Family planning fits in well with the overall concept of preventive care since an effective means of reducing infant and maternal mortality, as well as malnutrition among infants and children under five, is a child spacing program (family planning).

Finally, the research component under this project will also be concerned with the role of women within the health care system. The research unit will monitor the effectiveness of training, the community-level health education program, and the general impact of the health model, so as to gain new knowledge and insights into how the program can be improved.

D. Administrative Analysis

1. MOH Administrative Arrangements

This project will be administered by the Director of NIHS who will simultaneously hold the new position of Deputy Director for Health Manpower Development in the Directorate of Health Services of the Ministry of Health.

Five additional staff positions for the faculty and one for Deputy Director and development of a new three-year curriculum for Assistant Medical Practitioners at the site have been approved.

Three new Deputy Director positions have also been established: for Health Services, for Training, and for Research. WHO has agreed to provide: (a) three visiting faculty members during the life of this project so as to release existing faculty for additional training; (b) nine fellowships for faculty training; and (c) an Institute manager to serve as Acting Deputy to the Director while a local administrator is selected and trained.

The NIHS has five integral parts: the former Institute of Hygiene, the Kalutara Base Hospital, a peripheral hospital and two rural hospitals along with a surrounding service area of 52 square miles. NIHS will begin expanding training in September of 1980 while awaiting construction of the new buildings.

In order to suggest policy and make Institute services available to the country as a whole, a Board of Advisors has been constituted consisting of representatives of ministries who may need health services or need to coordinate public health programs. This advisory board will be responsible for recommending policy and budget. They will help resolve problems that may arise involving the scope of the Institute's educational service and research programs. However, administration and management of the Institute program falls to the Institute Director who is appointed by the Minister of Health. The Board would meet once or twice a year.

In addition to the Advisory Board, a joint GSL/Donor Program Committee will be established to provide coordination, technical guidance, monitoring and evaluation for the program. The Committee would consist of representatives from NIHS, UNICEF, WHO, UNDP and USAID. The committee probably would meet about monthly upon call of the Director of NIHS.

2. AID Project Arrangements

The USAID role in the project will be confined to (a) monitoring the contractors for A/E and construction; (b) participating in joint evaluations; and (c) participating as member of the joint GSL/Donor Program Committee.

USAID may finance an expatriate consultant who is an expert in campus planning and architecture to advise on design and then to monitor local contractors during facilities planning and construction phases of the project through short term trips to Sri Lanka. It is expected that the consultant will report to the USAID Project officer and NIHS director. If this expatriate consultant should be needed, the cost would be from the budget line item for design and supervision, although for budgeting purposes this is shown as local currency costs only.

Evaluations will be carried out as joint evaluations with all donors participating and may be combined with b. above. USAID will take responsibility for providing one or more team members of the joint evaluation teams to cover AID concerns.

E. Environmental Concerns

The Assistant Administrator for Asia Bureau on October 2, 1979 concurred in the PID's IEE recommendation for a Negative Determination; i.e. an environmental assessment would not be needed (State 276819, Oct. 23, 1979).

PART IV. THE FINANCIAL PLAN

Table I presents the summary budget for the NIHS program which includes the contributions from all donors including the GSL. No detailed breakdown is available at this time for the contributions from the other donors.

Table 2 is the disbursement schedule and inflation calculations for the AID grant funds. Table 3 is the detailed listing for the building program. A plot showing the buildings layout is in the Annex F.

The cost estimate in the GSL Project Proposal of 1978 did not provide an allowance for inflation and was preliminary. The Nutting-Salvo Report recognized the need for inflationary allowance and compared the original costs with the 1980 costs provided by the Colombo contractor (Tudawe Brothers, Ltd.) building the new American Embassy building. The comparison, however, was not completely valid as the type and complexity of construction differed greatly. The Nutting-Salvo Report also referred to reports of local inflation rate of 50% - 100%. Although the inflation rate for local construction has not been analysed in detail, it appears that a major portion of the increase was due to the GSL's adjustment in the price of locally made cement in late 1979 which about doubled the price of cement. Since this was a one-time adjustment in a major construction commodity, it is not anticipated that construction costs in the next several years are likely to increase more rapidly than general inflation. In accordance with the Mission's standard practice on treatment of inflation and contingency in financial planning, the rates of 10% per year for foreign exchange and 20% per year for local costs plus 10% for contingency are used in this PP.

In the preparation of this PP, discussions were held with the local architectural firm, Design Associated Ltd., doing some Kalutara design work for UNICEF. UNICEF is using for its cost estimates the unit cost of construction negotiated in 1980 between the GSL and the consortium of contractors. Since this seemed to be the most reliable, current information on construction costs, this per-unit construction costs are used in the financial analysis.

The allowance for design and supervision is as follows: 4% for design of utilities, 6% for design of buildings and 10% for supervision of construction of buildings and utilities. The costs for utilities, drainage and landscaping are based on the UNICEF's architect's estimate. Land and GSL-financed building costs are based on amount of GSL's actual contracts or costs already incurred.

In this financial plan, GSL's operating costs (described in the PID as recurring costs and personnel) were not included in accordance with the Mission's standard practice on project costing. Since such costs represent recurring expenses that will continue after the Program/Project is completed, they are not capital investment costs as such and the inclusion would distort the financial planning.

Since the PID was based on the GSL 1978 proposal and the project, including financial planning, has undergone some modifications, a simple direct comparison of the financial plan in this PID with that in the PID would not serve a useful purpose.

In summary, sufficient information is available for a reasonably firm estimate of the cost of the program and project and for satisfaction of Section 611(a).

TABLE I

SUMMARY COST ESTIMATE AND FINANCIAL PLAN
(US \$ 000)

	<u>A I D</u>			<u>GSL</u>	<u>W H O</u>			<u>U N I C E F</u>			<u>UNDP</u>	<u>T O T A L</u>
	<u>FX</u>	<u>LC</u>	<u>TOTAL</u>	<u>LC</u>	<u>FX</u>	<u>LC</u>	<u>TOTAL</u>	<u>FX</u>	<u>LC</u>	<u>TOTAL</u>	<u>FX</u>	
1. Design & Supervision	-	173	173	-	-	-	-	-	-	-	-	173
2. Construction	200	430	630	-	-	-	-	-	353	353	-	983
3. Surface Drainage	-	-	-	125	-	-	-	-	-	-	-	125
4. Land Acquisition	-	-	-	62	-	-	-	-	-	-	-	62
5. Utilities & Related Equipment	-	405	405	-	-	-	-	-	-	-	-	405
6. Furnishing	-	-	-	280	-	-	-	237	-	237	-	517
7. Technical Assistance	-	-	-	-	200	-	200	-	-	-	359	559
8. Training	-	-	-	-	85	25	110	180	-	180	141	431
9. Landscaping	-	15	15	-	-	-	-	-	-	-	-	15
10. Evaluation	50	-	50	-	-	-	-	-	-	-	-	50
11. Other GSL Investments	-	-	-	537	-	-	-	-	-	-	-	537
Sub-Total	250	1,023	1,273	1,004	285	25	310	417	353	770	500	3,857
Inflation	60	669	729	100	-	-	-	-	-	-	-	829
Contingency	30	168	198	116	-	-	-	-	-	-	-	314
TOTAL	340	1,860	2,200	1,220	285	25	310	417	353	770	500	5,000

REMARKS ON TABLE I

1. UNICEF construction costs include design/supervision costs of UNICEF buildings and related engineering services.
2. Inflation and contingency not included in WHO, UNICEF and UNDP contributions. Inflation for GSL inputs at 10 percent and not compounded. Inflation for AID inputs compounded.
3. Utilities include water supply, sewage disposal, road works and boundary walls.
4. Procurement of equipment will be locally done.
5. Site preparation and excavations included in construction costs.
6. Related equipment refers to telephones, airconditioning, lighting, generators.
7. Other GSL investments include buildings under construction and to be constructed both in the 'HHS compound' as well as the field areas.

AID INPUTS

Disbursement Schedule & Inflation Calculations

INPUT	US \$ 000				<u>TOTAL</u>
	<u>YEAR</u>				
	1981	1982	1983	1984	
I. Foreign Costs					
Construction	-	200	-	-	200
Evaluation	10	10	10	20	50
Sub Total	10	210	10	20	250
Plus Inflation	1	45	4	10	60
Sub Total	11	255	14	30	310
Plus Contingency 10%	1	25	1	3	30
TOTAL FOREIGN COSTS	12	280	15	33	340
Inflation factor applied	10%	21%	33%	46%	
<hr/>					
II. Local Costs					
Design & Supervision	75	20	30	48	173
Utilities & Equipment	150	120	105	30	405
Construction	-	30	200	200	430
Landscaping	15	-	-	-	15
Sub Total	240	170	335	278	1023
Plus Inflation	50	75	244	300	669
Sub Total	290	245	579	578	1692
Plus Contingency 10%	29	25	57	57	168
TOTAL LOCALS COSTS	319	270	636	635	1860
Inflation factor applied	20%	44%	73%	108%	
TOTAL LOCAL AND FOREIGN COSTS	<u>331</u>	<u>550</u>	<u>651</u>	<u>668</u>	<u>2200</u>

TABLE 2

TABLE 3
BUILDING PROGRAM

I. AID-Financed

	(Feet) Sq.Area	Rs. Cost Per Sq Ft.	Rs. Total Cost (000)	US\$ Equivalent (000)
A. Buildings				
1. Auditorium	5000	600	3000	188
2. Library/Documentation Administration and Staff Rest Rooms	3500	500	1750	109
3. Six Lecture Halls	4200	350	1470	92
4. Two Seminar Rooms	2000	350	700	44
5. Audio Visual Labs	1000	350	350	22
6. Demonstration Rooms	1000	300	300	19
7. Demonstration Center	2000	300	600	35
8. Six Lab Rooms	4200	350	1470	30
9. Cafeteria	1500	300	450	92
Sub Total	<u>24400</u>		<u>10090</u>	<u>630</u>
B. Utilities				
1. Water Supply			850	53
2. Sewage Disposal			500	31
3. Road Works			1200	75
4. Boundary Walls			240	15
Sub Total			<u>2790</u>	<u>174</u>
C. Equipment				
1. Lighting			700	44
2. Generators			500	31
3. Telephones			400	25
4. Air Conditioning			2000	125
5. Fire Extinguishers			100	6
Sub Total			<u>3700</u>	<u>231</u>
TOTAL AID FINANCED			16580	1055
II. UNICEF Financed				
1. Three Grade V Quarters)				
2. Two Grade IV Quarters)				
3. Two 25 Room Hostels)			5648	353
TOTAL UNICEF FINANCED			5648	353
III. GSL Financed				
1. Anatomy Block			1500	94
2. Administration Block for hospital			900	57
3. New Surgical Ward			1000	62
4. 25 Bed Wards			500	31
5. Two Grade V Quarters for hospital			1000	62
6. Peripheral Unit			1500	94
7. Two Grade V Quarters at rural hospital			1000	62
8. Director's Bungalow			500	31
9. First Aid/Stores/Garages			700	44
TOTAL BUILDING PROGRAMME			<u>8600</u>	<u>537</u>
TOTAL BUILDING PROGRAMME			<u>30028</u>	<u>1925</u>

PART V. THE IMPLEMENTATION PLAN

WHO and UNICEF representatives in Sri Lanka will coordinate implementation of the NIHS program in cooperation with the Ministry of Health and the Director of NIHS. USAID will participate in the program implementation by being on the joint GSL/Donor Program Committee, by participating in evaluation, and by monitoring the construction progress of the AID-financed facilities. The implementation Plan presented here, however, is for the AID-financed inputs only.

Design and Supervision of Construction: The design work will be done by a Sri Lankan firm (probably the one being used by UNICEF) under a host country contract. Construction supervision will also be done by a Sri Lankan firm which probably will be the firm doing the design work.

Construction: This will be done under one or more contracts between the GSL and local contractors following the GSL's regular bidding and contracting procedures.

USAID Monitoring: The project is designed to require minimum demands on the limited USAID direct-hire staff. Until such time as a human resources officer is on board (position approved in FY 80) USAID's management responsibilities will be in the Office of Project Development and Support.

USAID will approve the contracts for design/supervision and construction as well as the construction plans and specifications in accordance with AID's regular procedures. An appropriate reporting system will be set up in cooperation with the other donors to permit close monitoring of the program with minimum demands made on the NIHS administrative staff.

Project Schedule

PP approved	August 11, 1980
CN waiting period expires	August 27, 1980
Grant Project Agreement signed	August 29, 1980
Initial Conditioning Precedent met	October 31, 1980
Contract for design signed	December 1, 1980
Contract for construction signed	July 1, 1981
First formal evaluation	December 1981
PACD	August 29, 1984

PART VI. PROGRAM/PROJECT EVALUATION

The donors and GSL have agreed to establish an evaluation program as part of the Project. To carry out the evaluation, a data base should be established early in the project life. A fairly extensive system of impact and effectiveness data collection will be needed. Data should be available to make comparisons between: (1) different modes staffing of health centers; (2) different team compositions of health personnel; (3) different curricula for each level of worker; and (4) different training methods for village volunteers.

Indicators of performance will need to be reasonably simple, mostly obtained through surveys and questionnaires, plus information on Kalutara's own development gleaned from students, and staff of the Institute. The evaluations will seek out gaps and bottlenecks in project plan and assist NIHS personnel to modify plans to resolve problems that may arise. A general idea of the costs of different delivery models should also result from the data collection. The evaluation team will include representatives from WHO, UNICEF, UNDP, USAID and the GSL. Assistance with data collection procedures and survey preparations will be provided through consultant assistance by the donors as agreed and approved by the NIHS administration. AID has budgeted \$50,000 for evaluation on the functioning of the Institute, the health care delivery models, training curriculum, and impact on recipients.

Many interrelated problems in Sri Lanka must be solved in the course of developing effective preventive health care. These include increased salaries and salary scale adjustment opportunities favoring field service and field technical and professional work, improved housing, career ladders, jointly negotiated transfers of staff, and improved working conditions. The evaluation will report progress in the above areas with particular attention to details that may help in improving performance and morale of field workers; e.g. freedom to engage in limited private practice, assistance with transportation, supply of equipment kits and uniforms, performance awards and other such matters. Evaluation will examine GSL commitment to shift priorities towards preventive and community level primary health care; i.e., changes in health manpower distribution patterns, growth of primary health care facilities in rural areas, shifts in budgetary allocations, expansion of health volunteer training, and establishment of nationwide nutrition and health surveillance data collection and analysis.

PART VII. CONDITIONS AND COVENANTS**Conditions Precedent for Initial Disbursement**

In addition to the usual condition concerning authorized representatives, the grant agreement shall include the following conditions precedent:

1. Evidence of the commitment of other donors (UNICEF, UNDP and WHO) to the program of assistance to NIHS.
2. Evidence that adequate GSL budgetary resources are being made available for 1981 and assurances that further budgets for 1982-84 will provide adequate funding for the physical expansion of the facilities at NIHS and for the expanded program of instruction.

Conditions Precedent for Disbursement for Construction

In addition to the Standard Provisions Annex concerning approval of contracts, plans, bidding, etc., the grant agreement shall include the following conditions for initial disbursement for construction:

1. A revised and updated plan for the development of NIHS which shall include, among other things: (a) a site analysis; (b) a campus master plan; (c) construction details and schedule for the entire NIHS complex, including utilities, drainage, etc.; (d) program for staff increases and upgrading; (e) training program for all courses; (f) curriculum revision; and (g) usage of consultants.

2. Evidence that the GSL has delegated to the Director of NIHS, appropriate authority and autonomy to: (a) select and recruit the faculty for NIHS, including recommendations for appointments to the Ministry of Health positions assigned to NIHS; (b) refuse unacceptable faculty candidates proposed by the Ministry; (c) remove faculty and staff not performing satisfactorily; and (d) schedule its training, new program development, staff improvement and research.

3. Evidence that NIHS has an interim long term resident advisor for administration to assist the Director of NIHS until such time as a Sri Lankan can be selected and trained in institutional management.

4. Evidence that the GSL has delegated to the Director of NIHS appropriate authority to establish a facilities operations and maintenance office with sufficient staff and budget to operate and maintain all of the physical facilities of NIHS.

Special Covenants

In addition to the usual covenant regarding evaluation, the grant agreement shall include the following covenant:

1. The GSL covenants that it will implement the revised master plan submitted in satisfaction of the condition precedent and as the master plan may be modified from time to time with the approval of AID.

NATIONAL INSTITUTE OF HEALTH SCIENCES

PROJECT PAPER

ANNEXES

- A. Logical Framework
- B. PID Approval Cable
- C. GSL Application
- D. Section 611 (a) Determination
- E. Tables
- F. Site Plot
- G. Statutory Checklist

**PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK**

Life of Project:
From FY _____ to FY _____
Total U. S. Funding _____
Date Prepared: _____

Project Title & Number: **AID PROJECT**

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p>Program or Sector Goal: The broader objective to which this project contributes:</p> <p>To enhance human productivity and well-being in the rural sector by improving public health services.</p>	<p>Measures of Goal Achievement:</p> <p>Reduction in major preventable illnesses. Lowered malnutrition rates.</p>	<p>National statistics Special surveys</p>	<p>Assumptions for achieving goal targets: GSL devotes increased funding to Rural health services. Graduates are willing to work in Rural communities throughout Sri Lanka. Graduates are accepted by and able to work effectively in Rural communities.</p>
<p>Project Purpose:</p> <p>Expand physical facilities of NIHS in support of multi-donor program as described in Program Log frame.</p>	<p>Conditions that will indicate purpose has been achieved: End of project status.</p> <p>Facilities fully equipped, furnished and being used for teaching and research.</p>	<p>Joint evaluations Site visits</p>	<p>Assumptions for achieving purpose:</p> <p>GSL provides furnishings for buildings. NIHS is able to retain its staff.</p>
<p>Outputs:</p> <p>Construction of physical facilities</p>	<p>Magnitude of Outputs:</p> <p>Auditorium Library 6 Lecture halls 2 Seminar rooms 6 Lab rooms, audio visual lab. Demonstration room, demonstration center, Cafeteria, utilities, site preparation and roadway</p>	<p>A/E reports Site visits</p>	<p>Assumptions for achieving outputs:</p> <p>Local construction industry has capacity and willingness to construct the NIHS building</p>
<p>Inputs:</p> <p>AID - construction, architect/engineering services GSL - Land, furnishings, equipment, landscaping, related buildings</p>	<p>Implementation Target (Type and Quantity)</p> <p>AID - \$ 2.2 million grant GSL - \$ 1.0 million</p>	<p>AID documents</p>	<p>Assumptions for providing inputs:</p> <p>GSL provides its inputs</p>

**PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK**

Life of Project:
From FY _____ to FY _____
Total U. S. Funding _____
Date Prepared: _____

Project Title & Number: **NIHS PROGRAM**

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS																				
<p>Program or Sector Goal: The broader objective to which this project contributes:</p> <p>To enhance human productivity and well-being in the rural sector by improving public health services.</p>	<p>Measures of Goal Achievement:</p> <p>Reduction in major preventable illnesses. Lowered malnutrition rates.</p>	<p>National statistics Special surveys</p>	<p>Assumptions for achieving goal targets:</p> <p>GSL devotes increased funding to Rural health services. Graduates are willing to work in Rural communities throughout Sri Lanka. Graduates are accepted by and able to work effectively in Rural communities.</p>																				
<p>Project Purpose:</p> <p>To increase the capacity of the National Institute of Health Sciences (NIHS) to train the quantity and quality of health care workers required to improve GSL health delivery services and environmental sanitation.</p>	<p>Conditions that will indicate purpose has been achieved: End of project status.</p> <p>A) NIHS training annually about 60 AMP 80 PHI 50 FHW 40 PHN B) NIHS providing short-term courses. C) Health delivery models being designed and tested.</p>	<p>NIHS Reports Joint Evaluations Site Visits</p>	<p>Assumptions for achieving purpose:</p> <p>NIHS is able to retain qualified staff. NIHS is able to attract enough qualified students for long and short-term training program. GSL provides adequate budgetary support for NIHS.</p>																				
<p>Outputs:</p> <ol style="list-style-type: none"> Additional physical facilities constructed. Staff increased and skills upgraded. Curricula revised to address current rural health needs. 	<p>Magnitude of Outputs:</p> <ol style="list-style-type: none"> Auditorium Library Teaching facilities Hostels, related utilities internal roads, landscaping etc. Staff expanded to 125 professionals Revised curriculum installed for AMP, PHI & PHNs. 	<p>A/E reports Site visits</p>	<p>Assumptions for achieving outputs:</p> <p>Local construction industry is willing and able to construct the NIHS buildings. NIHS is able to recruit sufficient staff. Other donors provide sufficient TA to revise curriculum.</p>																				
<p>Inputs:</p> <p>UNICEF-Construction, scholarships TA</p> <p>WHO - TA and Adm, Assistance UNDP - TA and Adm, Assistance AID - Construction, Evaluation GSL - Land, construction, furnishings.</p>	<p>Implementation Target (Type and Quantity)</p> <table border="0"> <tr> <td>UNICEF</td> <td>-</td> <td>\$</td> <td>770,000</td> </tr> <tr> <td>WHO</td> <td>-</td> <td></td> <td>310,000</td> </tr> <tr> <td>UNDP</td> <td>-</td> <td></td> <td>500,000</td> </tr> <tr> <td>AID</td> <td>-</td> <td></td> <td>2,200,000</td> </tr> <tr> <td>GSL</td> <td>-</td> <td></td> <td>1,000,000</td> </tr> </table>	UNICEF	-	\$	770,000	WHO	-		310,000	UNDP	-		500,000	AID	-		2,200,000	GSL	-		1,000,000	<p>GSL and donor documentation</p>	<p>Assumptions for providing inputs:</p> <p>GSL and other donors provide sufficient money for all inputs.</p>
UNICEF	-	\$	770,000																				
WHO	-		310,000																				
UNDP	-		500,000																				
AID	-		2,200,000																				
GSL	-		1,000,000																				

AMR	✓
CHARGE	
DCM	✓
POL	
ECON	✓
E/LAB	
COMM	
CONS	
ADMIN	
GSO	
E+F	
PER	
C+R	
MED	
NCOIC	
TCU	
AID	
ICA	
DAO	
FBO	
CHRON	✓
TOTAL	11

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ANNEX B

HR	
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WM	
RI	
Date: <u>A/JP</u>	

AIDAC
 E.O. 12865: N/A

TAGS:
 SUBJECT: KALUTARA INSTITUTE OF HEALTH (383-2062)
 APAC

REFS: (A) STATE 258273; (B) COLOMBO 4827

1. APAC MET SEPTEMBER 28 AND APPROVED PID. THE FOLLOWING ISSUES WERE DISCUSSED.

(A) AS INDICATED REF (A), THIS PROJECT WAS DELETED FROM FY 81 IDCA BUDGET PRESENTATION TO OMB, BUT DOLS 14 MILLION FOR GTE WATER DEVELOPMENT UNQTE WAS INCLUDED. WE THEREFORE PROPOSE TWO ALTERNATIVES FOR THE FY 81 CONGRESSIONAL PRESENTATION AND REQUEST THAT MISSION PROVIDE THE FOLLOWING:
 ... (1) SEPARATE DATA SHEETS FOR THIS PROJECT, FOR THE JAFFNA MARKET TOWN WATER PROJECT, AND FOR A SEPARATE DOLS. 12 MILLION-WATER DEVELOPMENT SECTOR PROJECT. UNDER THIS APPROACH, WE WILL MAKE EVERY EFFORT TO HAVE THIS AND THE JAFFNA PROJECT REINSTATED AS REGULAR FY 81 PROJECTS. WE WILL ALSO CONSIDER THEM FY 80 SHELF PROJECTS. A PID FOR THE SEPARATE WATER DEVELOPMENT SECTOR PROJECT WOULD HAVE TO BE SUBMITTED TO AID/W FOR APPROVAL. (NOTE HOWEVER, IF WE ARE NOT REPEAT NOT SUCCESSFUL IN GETTING THIS AND JAFFNA

PROJECTS REINSTATED, WE WOULD THEN PROCEED WITH FOLLOWING ALTERNATIVE..)

... (2) A SINGLE DATA SHEET FOR A DOLS 12 MILLION WATER DEVELOPMENT PROJECT, INCLUDING REPEAT INCLUDING THE SUBSTANCE OF THIS AND THE JAFFNA PROJECT AS COMPONENTS. A SECTOR OR OVERALL WATER PROJECT, FOR EXAMPLE, COULD EMPHASIZE THE ROLE OF THE KALUTARA INSTITUTE IN PROVIDING TRAINED PERSONNEL FOR SAFE WATER USE, FOR IMPROVED SANITATION IN CONNECTION WITH EXPANDED WATER AVAILABILITY, ETC. SIMILARLY, JAFFNA PILOT OR EXPERIMENTAL COMPONENT AND MASTER PLAN COULD BECOME VEHICLES FOR TESTING BOTH PROCEDURES AND SYSTEMS WHICH THEN HAVE POTENTIAL FOR BROADER APPLICATION. THE OVERALL PROJECT WOULD ALSO PRESUMABLY INCLUDE OTHER WATER RELATED ELEMENTS.

(3) APAC FELT STRONGLY THAT THIS PROJECT SHOULD BE LINKED TO A GSL NATIONAL PROGRAM ON HEALTH SERVICES DELIVERY, ESPECIALLY AS IT RELATES TO IMPROVED WATER AND ENVIRONMENTAL STANDARDS. THE FP SHOULD ADDRESS

IN DETAIL A GSL COMMITMENT TO THE NATIONAL PROGRAM, ESPECIALLY THE LEVEL OF FUNDING EARMARKED IN THE GSL'S BUDGET FOR A NATIONAL HEALTH PROGRAM. THE PP ANALYSIS SHOULD ALSO INCLUDE ANY OTHER AVAILABLE EVIDENCE OF A STRONG GSL COMMITMENT TO A NATIONAL PROGRAM OF HEALTH IMPROVEMENT.

UNCLASSIFIED

UNCLASSIFIED ANNEX B

(C) THE APAC NOTED THAT THERE IS A CURRENT SHORTFALL OF MORE THAN 2,002 PERSONS IN ADDITION TO THE AVERAGE 132 PERSONS PER YEAR THAT MUST BE TRAINED TO ACHIEVE THE OPTIMUM MANPOWER STANDARD, AND QUESTIONED WHETHER INSTITUTE WOULD BE SUFFICIENTLY STRENGTHENED BY THIS RELATIVELY LIMITED PROJECT TO BE ABLE TO CARRY OUT THAT TASK. APAC QUESTIONED WHETHER MORE TECHNICAL ASSISTANCE TO THE INSTITUTE WAS NEEDED THAN IS CURRENTLY CONTEMPLATED. THE PP MUST FULLY EXPLORE THE QUESTION OF THE IMPROVED INSTITUTE'S ABILITY TO PERFORM THE NECESSARY TASKS, INCLUDING AN IN-DEPTH ANALYSIS OF PROFESSIONAL SKILLS AND MANAGEMENT CAPABILITY OF EXISTING STAFF AT THE INSTITUTE, AND IDENTIFY IN-HOUSE TRAINING AND/OR ACTIONS THAT MAY BE NECESSARY TO IMPROVE ORGANIZATIONAL CAPACITY.

(D) THE APAC UNDERScoreD NEED FOR AN ADEQUATE EVALUATION PLAN FOR THE PROJECT, AND THE NEED FOR SUBSTANTIAL BASELINE DATA AND AN ADEQUATE MANAGEMENT INFORMATION/REPORTING SYSTEM.

(E) APAC NOTED THAT FINANCIAL PLAN PROVIDES FOR FUNDING OF INFLATION AND CONTINGENCIES BEFORE MAJOR FINANCING ACTIVITIES TAKE PLACE. SUGGEST YOU REPROGRAM THOSE FUNDS FOR LATER IN THE PROJECT.

(F) FINALLY, THE QUESTION OF THE SHORTFALL IN DONOR FUNDS WAS DISCUSSED. CONSENSUS OF APAC WAS THAT 1. ANALYSIS IN PP DETERMINED THAT ADDITIONAL FUNDS WERE NECESSARY TO COVER THE SHORTFALL OR TO ASSIST IN THE EVALUATION, EVERY EFFORT WOULD BE MADE BY AID/W TO COME UP WITH THOSE ADDITIONAL FUNDS.

2. FYI, THE IEE NEGATIVE DETERMINATION FOR THIS PROJECT WAS SIGNED BY AA/ASIA ON OCTOBER 2, 1979. END FYI. CHRISTOPHER
BT
#6819

ACTION
AID-7
INFO

UNCLASSIFIED

TELEGRAM

AMERICAN EMBASSY COLOMBO

24 OCT 1979

AID	Action	Info
DIR		
AD		

UNCLASSIFIED

Page 7 of 9

Classification

EXCERPT FROM COLOMBO 3748

AUGUST 5, 1980.

ANNEX B

DONOR INPUTS ARE COORDINATED WITH AID EX INPUTS.

7. IN PROJECT DEVELOPMENT, WE HAVE TAKEN INTO
STATE 276819, 23 OCT, 1979.
ACCOUNT THE APAC SUGGESTIONS IN REF B/AS FOLLOWS:

(A) RE PARA B, THE DEVELOPMENT OF KALUTARA
INSTITUTE IS LINKED TO THE GSL NATIONAL PROGRAM
OF HEALTH SERVICES DELIVERY SINCE IT HAS BEEN
RAISED IN STATUS TO A NATIONAL LEVEL RESOURCE AND
IT WILL EXPAND THE NATIONAL CAPACITY TO TRAIN ASSIS-
TANT MEDICAL PRACTITIONERS AND PUBLIC HEALTH NURSES
BY 50 PERCENT. NINS ALSO TRAINS FAMILY HEALTH
CARE WORKERS AND ALL PUBLIC HEALTH INSPECTORS.
NINS OUTPUT NEED MORE THAN DOUBLE BY 1983. ~~FROM~~
~~XXXXXXXXXX~~ NINS WILL ALSO REORIENT ALL CURRICULA
TO MEET PRIMARY HEALTH CARE DELIVERY NEEDS AT THE
PERIPHERY AND UNDERTAKE RESPONSIBILITY FOR HEALTH
MANPOWER RESEARCH AND TRAINING FOR ALL LEVELS OF THE
PRIMARY HEALTH CARE TEAM. RECENT DECLARATIONS OF GSL
COMMITMENT TO STRENGTHEN PRIMARY HEALTH CARE IN LINE
WITH THE ALMA ATA GOALS, ARE CONTAINED IN THE
PRESENTATION MADE AT JUNE W.H.O. MEETING IN NEW
DELHI (A COPY OF THE PRESENTATION SHOULD NOW HAVE
REACHED THE DESK). THE NATIONAL HEALTH DEVELOPMENT
COMMITTEE IS NOW DRAFTING NATIONAL PLAN OF ACTION FOR
PHC. NATIONAL HEALTH COUNCIL CHAIRED BY PRIME

UNCLASSIFIED

Classification

OPTIONAL FORM 153A
(Formerly FS-413A)
January 1975
Dept. of State

~~XXXXXXXXXXXXXXXXXXXX~~

MINISTER WILL PROVIDE INTERSECTORAL COORDINATION AND SUPPORT FOR THE PHC PLAN.

(B) RE PARA C, THE SHORTFALL IN HEALTH PERSONNEL WILL BE SUBSTANTIALLY REDUCED AS A RESULT OF NIHS DEVELOPMENT PLANS, AS SHOWN IN NUTTING/SALVO REPORT. BEYOND THAT THE MOH IS EXPANDING ITS PROGRAM FOR VILLAGE BASED VOLUNTEER HEALTH WORKERS WHO ARE ALREADY BEING WELL RECEIVED BY THE PUBLIC. (SEE HEALTH, POPULATION AND NUTRITION SECTOR REVIEW BY BRADY, LASHMANI AND MAC CORQUODALE). MOREOVER, THE GSL DECADE OF WATER AND SANITATION PLAN CALLS FOR THE NIHS TO PLAY A MAJOR ROLE IN TRAINING THE PERSONNEL NEEDED FOR A GREATLY EXPANDED PROGRAM IN THIS AREA.

(C) RE PARA D, EVALUATIONS WILL BE DONE JOINTLY WITH OTHER DONORS. AID PLANS TO SUPPLY FUNDING AND SOME CONSULTANT SUPPORT FOR THE DEVELOPMENT OF EVALUATION AND DATA COLLECTION METHODOLOGIES DURING THE FIRST YEAR OF THE PROJECT.

(D) RE PARA E, FINANCIAL PLAN NOW INCLUDES ADEQUATE ALLOWANCE FOR ~~INFLATION~~ INFLATION AND CONTINGENCIES PER MISSION PRACTICE DESCRIBED IN COLOMBO 2846.

UNCLASSIFIED

Classification

(E) RE PARA F, SHORTFALL IN FUNDS IS ~~NOT~~ NOW COVERED BY PROPOSED INCREASED AID ASSISTANCE AND INCREASED ASSISTANCE FROM OTHER DONORS. NOTE THAT AID/W SUGGESTED THAT IF ADDITIONAL FUNDS (I.E. MORE THAN DOLLARS 500,000) SHOULD BE NEEDED, ~~THESE FUNDS SHOULD~~ ~~BE PROVIDED~~, AID SHOULD TRY TO PROVIDE THESE.

8. ALTHOUGH THE PURPOSE OF AID ASSISTANCE HAD NOT CHANGED, THE REQUIRED FINANCING HAS INCREASED. SINCE AID LIFE-OF-PROJECT FUNDING IS STILL UNDER THE DOLLARS 5 MILLION CEILING FOR WHICH DIRECTOR HAS AUTHORITY TO AUTHORIZE, MISSION PLANS TO APPROVE PROJECT OF DOLLARS 2.2 MILLION GRANT FOR LIFE-OF-PROJECT WITH DOLLARS 500,000 BEING OBLIGATED IN FY 90 AND BALANCE IN FUTURE YEARS SUBJECT TO USUAL CONDITIONS.

9. ADVISE SOONEST.

TOUSSAIN 

දුරකථන
Telephone } 21103
දුරකථන
Telegrams } FONAID
දුරකථන
Cable } FONAID
දුරකථන
Telex } 1332



විදේශ සම්පත් දෙපාර්තමේන්තුව
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 අ.ප. විද්‍යාල සංවිධාන
DEPARTMENT OF EXTERNAL RESOURCES
 Ministry of Finance & Planning

ANNEX C
 TA 9/1/1 S
 My No.
 Your No.

සැලකිය යුතු (2 වන පෙළ)
 කුලීන්ගේ ගෞරව (2 වන පෙළ)
 Ceylinca House (2nd Floor)
 No. 277, Galle Road
 P.O. Box 277, Colombo 1

4 April, 1978.

Dear Ms. Littlefield,

Development of the National Institute of Health Sciences - Kalutara

I forward herewith a project proposal submitted by the Secretary, Ministry of Health.

"The Ministry of Health has obtained Cabinet approval for the above project. This project is to be implemented during the five year period 1979 - 1983 in two phases.

The External inputs envisaged is as follows :

Phase I 1979 - 1980	US \$	1,030,350
Phase II 1981 - 1983	" "	943,700
		Total 20003050

Approx : US \$ 2 mn."

The UNICEF has allocated \$ 770,000 towards the implementation of this project in the period 1979 - 1983. WHO has allocated \$ 30,000 initially for 1979/1980. A further commitment of \$ 121,700 is envisaged from WHO. This leaves a balance of approximately \$ 1 mn. to be obtained from other potential donors."

I shall be glad if this request is considered favourably.

Yours sincerely,

(Signature)
 (M.A. Mohamed)
 Addl. Director

Ms. S.J. Littlefield,
 Director,
 US AID,
 C/o American Embassy,
 Colombo 5.

ALD	Action	Ind
DIR		✓
AID		✓
PRD		✓
PS		
ON		
MD		
ED		✓
FD		
AM		
LI		
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...		

UNITED STATES OF AMERICA
INTERNATIONAL DEVELOPMENT COOPERATION AGENCY
AGENCY FOR INTERNATIONAL DEVELOPMENT
c/o American Embassy, Colombo, Sri Lanka.

August 12, 1980

CERTIFICATION PURSUANT TO SECTION
611 (a) OF THE FOREIGN ASSISTANCE
ACT OF 1961, AS AMENDED

I, Sarah Jane Littlefield, the Director of the Agency for International Development Mission to Sri Lanka, having taken into account, among other things, the maintenance and utilization of projects in Sri Lanka previously financed or assisted by the United States, do hereby certify that in my judgement Sri Lanka has both the financial and human resource capabilities to effectively maintain and utilize the National Institute of Health Sciences Project Number 383-0062.



S.J. Littlefield
Director

ANNEX E

Table I - Type of Health Institutions in Sri Lanka (1972 and 1977 data)

Sector (year)	Type of Institution	Number of Institutions
Government Western (1977)	Teaching hospitals	2
	Provincial hospitals (\pm 600 beds)	9
	Base hospitals (\pm 250 beds)	18
	District hospitals (\pm 100 beds)	109
	Peripheral units (\pm 50 beds)	108
	Rural hospitals (\pm 20 beds)	87
	Maternity homes (\pm 12 beds)	27
	Central dispensaries (small outpatient unit)	385
	Branch dispensaries	137
	Visiting stations (part time)	566
	Specialized and other hospitals	22
	Sub-Total	<u>1,470</u>
Government Ayurveda (1972)	Ayurveda hospitals	7
	Ayurveda dispensaries	211
	Sub-Total	<u>218</u>
Private Western	Nursing homes	62
	Co-operative hospitals	14
	Estate hospitals	66
	Estate maternity homes	115
	Private practitioners	530
	Sub-Total	<u>787</u>
Private Ayurveda	Private practitioners	9,823
	Sub-Total	<u>9,823</u>
Total - All sectors		<u>12,298</u> *****

ANNEX E

Table II Health Personnel in Sri Lanka, 1978

Category	In Government Service	Non-Government*	Total
<u>Western Type (Total)</u>	29250	9950	43540
Doctors	2229	1033	3262
Nurses	5938	797	6735
Midwives Hospital Field	1388) 3529 2141)	192	3721
Dental Surgeons	249	100	349
Asst. Medical Practitioners	1051	143	1194
Public Health Inspectors	998	129	1127
Medical Laboratory Technologists	475	55	530
Radiographers	153	20	173
Physiotherpists	139	15	154
Dental Nurses	332	29	361
Pharmacists	442	49	491
Dispensers	735	96	831
Attendants-Male Attendants-Female	2167) 5043 2876)	632	5675
Other workers	8007	1000	19007
<u>Ayurveda (Total)</u>	<u>983</u>	<u>4290</u>	<u>10933</u>
Doctors	293	9950	10243
Other workers	690	-	690

Source: Ministry of Health (Planning Units)

*Estimates

ANNEX E

TABLE III - Percentage of National Budget Allocated to Health, Education, Other Social Services and Food Subsidies. 1975-1980

	<u>1975</u>	<u>1976</u>	<u>1977</u>	<u>1978</u>	(Est.) <u>1979</u>	(Est.) <u>1980</u>
Health	4.5%	4.7%	5.1%	3.6%	4.4%	3.8%
Education	9.2	9.5	10.0	6.6	6.5	6.9
Other Social Services	1.2	2.3	1.7	0.7	1.2	1.1
	—	—	—	—	—	—
Sub-Total	14.9	16.5	16.8	10.9	12.1	11.8
Food Subsidies	14.0	11.6	11.6	12.5	12.3	5.6
	—	—	—	—	—	—
Total Percentage	28.9%	28.1%	28.4%	23.4%	24.4%	17.4%
Total Budget (Millions of Rupees)	7770	9037	9405	16,831	19,614	23,387

TABLE IV - PROJECTED TRAINING OUTPUT OF NIHS
BY 1983

Discipline	No trained annually at Institutel/	No trained annually in Sri Lanka	% Total output at Institute currently	Projected No to be trained annually by 1983 at NIHS	Projected No to be train -ed annually in Sri Lanka	% Total trained at NIHS in 1983	Increa- annua! NIHS output
PHI	75	75	100%	80	80	100%	5 6.7%
PHN	0	0	-	40	40	100%	40 -
PHW	36	277	13%	50	320	16%	14 39%
AMP	0	90	0%	60	150	40%	60 -
TOTAL	111	442	25%	230	590	39%	119 107%

1/ Average of years 1975-1979

TABLE V CURRENT AND PROPOSED MANPOWER OF NIHS COMPLEX

	CURRENT STRENGTH NIHS COMPLEX		TOTAL	ADDITIONAL PROPOSED
	INSTITUTE	HEALTH UNIT		
Medical Officer	3	4	7	4
Medical Officers (Seconded) for AMP Training	0	0	0	8
Medical Officer (ADM)	1	-	1	3
Dental Officer	1	-	1	-
PHI	5	16	21	4
PHN	1	16	17	4
Public Health Tutor	4	-	4	-
Midwife	1	29	30	1
Librarian	1	-	1	-
Dental Nurse	7	-	7	-
Med. Lab. Tech.	6	-	6	-
Health Educator	-	-	-	1
Behav. Scientist	-	-	-	1
A.V. Officer/ Lecturer	-	-	-	1
Social Worker	-	-	-	1
Statistician	-	-	-	1
A.V. Technician	-	-	-	1
Library Assistant	-	-	-	1
Total Professional/ Technical	30	65	95	31
Clerical	3	2	5	19
Secy./Accountant	-	-	-	1
Book-Keeper	-	-	-	2
Other	25	1	26	13
Total Support Staff	28	3	31	35

ANNEX E

TABLE VI - GROSS REQUIREMENTS FOR TRAINING SPACE FOR MAJOR TRAINING ACTIVITIES

MAJOR SPACE REQUIREMENT FOR PLANNED TRAINING
(IN UNITS OF STUDENT-WEEKS)

<u>Training Course</u>	<u>Lecture/ Seminar</u>	<u>Laboratory</u>	<u>Total</u>
MOH	108	12	120
AMP 1st Year	1,248	1,560	2,808
2nd year	1,248	1,560	2,808
PHI	2,995	832	3,827
PHM	416	-	416
PHN	702	-	702
HE	180	-	180
SPHI	40	-	40
SPHM	360	-	360
SPHN	20	-	20
	<u>7,317</u>	<u>3,964</u>	<u>11,281</u>

Assumptions:

MOH:	30 students for 4 weeks; 90% Lecture/Seminar, 10% laboratory.
AMP:1st:	60 students for 52 weeks; 40% Lecture/Seminar; 10% field; 50% laboratory.
2nd:	60 students for 52 weeks; 40% lecture/seminar; 10% field; 50% laboratory.
PHI:	80 students for 52 weeks; 4 weeks (8%) in field; 72% Lecture/Seminar, 20% laboratory.
PHM:	40 students for 26 weeks; 3 days per week (60%) in field
PHN:	45 students for 39 weeks; 3 days per week (60%) in field
HE:	15 students for 12 weeks; 100% in classroom, no labs.
SPHI:	10 students for 4 weeks; 100% in classroom, no labs.
SPHM:	30 students for 12 weeks; 100% in classroom, no labs.
SPHN:	5 students for 4 weeks; 100% in classroom, no labs.

NATIONAL INSTITUTE
OF
HEALTH SCIENCES

SC(1) - COUNTRY CHECKLIST

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

GENERAL CRITERIA FOR COUNTRY ELIGIBILITY

- | | |
|---|--------------------------------------|
| 1. <u>FAA Sec. 116.</u> Can it be demonstrated that contemplated assistance will directly benefit the needy? If not, has the Department of State determined that this government has engaged in a consistent pattern of gross violations of internationally recognized human rights? | Yes |
| 2. <u>FAA Sec. 481.</u> Has it been determined that the government of recipient country has failed to take adequate steps to prevent narcotics drugs and other controlled substances (as defined by the Comprehensive Drug Abuse Prevention and Control Act of 1970) produced or processed, in whole or in part, in such country, or transported through such country, from being sold illegally within the jurisdiction of such country to U.S. Government personnel or their dependents, or from entering the United States unlawfully? | No |
| 3. <u>FAA Sec. 620(b).</u> If assistance is to a government, has the Secretary of State determined that it is not controlled by the international Communist movement? | Yes |
| 4. <u>FAA Sec. 620(c).</u> If assistance is to government, is the government liable as debtor or unconditional guarantor on any debt to a U.S. citizen for goods or services furnished or ordered where (a) such citizen has exhausted available legal remedies and (b) debt is not denied or contested by such government? | Not to the best of Mission knowledge |
| 5. <u>FAA Sec. 620(e)(1).</u> If assistance is to a government, has it (including government agencies or subdivisions) taken any action which has the effect of nationalizing, expropriating, or otherwise seizing ownership or control of property of U.S. citizens or entities beneficially owned by them without taking steps to discharge its obligations toward such citizens or entities? | No |

6. FAA Sec. 620(e), 620(f); FY 79 App. Act, Sec. 102, 112 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 guaranty 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? N/A
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?
 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? No
12. FAA Sec. 620(s). If contemplated assistance is development loan or from Economic Support Fund, has the Administrator taken into account the percentage of the country's budget which is for military expenditures, the amount of foreign exchange spent on military equipment and the N/A

A.12.

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

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

No

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

GSL is curre

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

No

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

No

B. FUNDING CRITERIA FOR COUNTRY ELIGIBILITY

1. Development Assistance Country Criteria

a. FAA Sec. 102(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?

Yes, CDSS

Page
SCI

B.1.

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

2. Economic Support Fund Country Criteria

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

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

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

d. FY 79 App. Act. Sec. 113. Will assistance be provided for the purpose of aiding directly the efforts of the government of such country to repress the legitimate rights of the population of such country contrary to the Universal Declaration of Human Rights? N/A

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

SC(2) - PROJECT CHECKLIST

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

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

A. GENERAL CRITERIA FOR PROJECT

- | | |
|---|---|
| 1. <u>FY 79 App. Act Unnumbered; FAA Sec. 653 (b); Sec. 634A.</u> (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) Congressional notification
(b) Yes |
| 2. <u>FAA Sec. 611(a)(1).</u> 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? | (a) Yes
(b) Yes |
| 3. <u>FAA Sec. 611(a)(2).</u> 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 legislative action is required |
| 4. <u>FAA Sec. 611(b); FY 79 App. Act Sec. 101.</u> 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. <u>FAA Sec. 611(e).</u> 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? | Yes |
| 6. <u>FAA Sec. 205.</u> Is project susceptible of execution as part of regional or multilateral project? If so why is project not so executed? Information and conclusion whether assistance will encourage regional development programs. | No |

7. FAA Sec. 601(a). Information and conclusions whether project will encourage efforts of the country to: (a) increase the flow of international trade; (b) foster private initiative and competition; (c) encourage development and use of cooperatives, credit unions, and savings and loan associations; (d) discourage monopolistic practices; (e) improve technical efficiency of industry, agriculture and commerce; and (f) strengthen free labor unions.
- (a) NA
(b) NA
(c) NA
(d) NA
(e) NA
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).
- NA
9. FAA Sec. 612(h); Sec. 630(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.
- GSL providing about 25 percent of costs. No available U.S. accrued local currency.
10. FAA Sec. 612(d). Does the U.S. own excess foreign currency of the country and, if so, what arrangements have been made for its release?
- No
11. FAA Sec. 601(e). Will the project utilize competitive selection procedures for the awarding of contracts, except where applicable procurement rules allow otherwise?
- Yes
12. FY 79 App. Act Sec. 608. If assistance is for the production of any commodity for export, is the commodity likely to be in surplus on world markets at the time the resulting productive capacity becomes operative, and is such assistance likely to cause substantial injury to U.S. producers of the same, similar, or competing commodity?
- NA
- 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
- (a) NA

2.1.a.

basis, using the appropriate U.S. institutions; (b) help develop cooperatives, especially by technical assistance, to assist rural and urban poor to help themselves toward better life, and otherwise encourage democratic private and local governmental institutions; (c) support the self-help efforts of developing countries; (d) promote the participation of women in the national economies of developing countries and the improvement of women's status; and (e) utilize and encourage regional cooperation by developing countries?

- (h) NA
- (c) Project to help GSL train in-country needed public health personnel
- (d) Women will be major beneficiaries of project
- (e) NA

b. FAA Sec. 103, 103A, 104, 105, 106, 107.

Is assistance being made available: (include only applicable paragraph which corresponds to source of funds used. If more than one fund source is used for project, include relevant paragraph for each fund source.)

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

NA

(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.

Yes. See project description

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

NA

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

- (i) technical cooperation and development, especially with U.S. private and voluntary, or regional and international development, organizations;
- (ii) to help alleviate energy problems;
- (iii) research into, and evaluation of, economic development processes and techniques;
- (iv) reconstruction after natural or man-made disaster;

8.1.b.(4).

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

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

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

N/A

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"?

Yes, yes

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.

Responds to health needs of people, develops local health training institutions.

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

Yes, through contributing to better health.

2. Development Assistance Project Criteria
(Loans Only)

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

NA

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

NA

8.

3. Project Criteria Solely for Economic Support Fund

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

NA

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

NA

5C(3) - STANDARD ITEM CHECKLIST

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

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

A. Procurement

- | | |
|--|-----|
| 1. <u>FAA Sec. 602.</u> Are there arrangements to permit U.S. small business to participate equitably in the furnishing of goods and services financed? | Yes |
| 2. <u>FAA Sec. 604(a).</u> Will all commodity procurement financed be from the U.S. except as otherwise determined by the President or under delegation from him? | Yes |
| 3. <u>FAA Sec. 604(d).</u> If the cooperating country discriminates against U.S. marine insurance companies, will agreement require that marine insurance be placed in the United States on commodities financed? | Yes |
| 4. <u>FAA Sec. 604(e).</u> If offshore procurement of agricultural commodity or product is to be financed, is there provision against such procurement when the domestic price of such commodity is less than parity? | NA |
| 5. <u>FAA Sec. 608(a).</u> Will U.S. Government excess personal property be utilized wherever practicable in lieu of the procurement of new items? | Yes |
| 6. <u>FAA Sec. 603.</u> (a) Compliance with requirement in section 901(b) of the Merchant Marine Act of 1936, as amended, that at least 50 per centum of the gross tonnage of commodities (computed separately for dry bulk carriers, dry cargo liners, and tankers) financed shall be transported on privately owned U.S.-flag commercial vessels to the extent that such vessels are available at fair and reasonable rates. | Yes |
| 7. <u>FAA Sec. 621.</u> If technical assistance is financed, will such assistance be furnished to the fullest extent practicable as goods and professional and other services from private enterprise on a contract basis? If the | Yes |

A.7.

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

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

Yes

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

Yes

B. Construction

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

No. Local firms to be used as justified in PP.

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

Yes

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

NA

C. Other Restrictions

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

NA

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

NA

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

Yes

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

Yes

C.

5. Will arrangements preclude use of financing:

- a. FAA Sec. 104(f). To pay for performance of abortions or to motivate or coerce persons to practice abortions, to pay for performance of involuntary sterilization, or to coerce or provide financial incentive to any person to undergo sterilization? **Yes**
- b. FAA Sec. 620(g). To compensate owners for expropriated nationalized property? **Yes**
- c. FAA Sec. 660. To finance police training or other law enforcement assistance, except for narcotics programs? **Yes**
- d. FAA Sec. 662. For CIA activities? **Yes**
- e. FY 79 App. Act Sec. 104. To pay pensions, etc., for military personnel? **Yes**
- f. FY 79 App. Act Sec. 106. To pay U.N. assessments? **Yes**
- g. FY 79 App. Act Sec. 107. To carry out provisions of FAA sections 209(d) and 251(h)? (Transfer of FAA funds to multilateral organizations for lending.) **Yes**
- h. FY 79 App. Act Sec. 112. To finance the export of nuclear equipment, fuel, or technology or to train foreign nations in nuclear fields? **Yes**
- i. FY 79 App. Act Sec. 601. To be used for publicity on propaganda purposes within United States not authorized by the Congress? **Yes**