

PD-AAL-404

JSN = 13634

0644

PP

9320644/42

AGENCY FOR INTERNATIONAL DEVELOPMENT PROJECT PAPER FACESHEET	1. TRANSACTION CODE <input checked="" type="checkbox"/> A ADD <input type="checkbox"/> C CHANGE <input type="checkbox"/> D DELETE	2. DOCUMENT CODE 3

3. COUNTRY/ENTITY Interregional	4. DOCUMENT REVISION NUMBER 2
------------------------------------	----------------------------------

5. PROJECT NUMBER (7 digits) 932-0644	6. BUREAU/OFFICE A. SYMBOL: DSB B. CODE: 36	7. PROJECT TITLE (Maximum 40 characters) FP Training for Paramedics/Auxiliaries
------------------------------------------	---------------------------------------------------	------------------------------------------------------------------------------------

8. ESTIMATED FY OF PROJECT COMPLETION FY 84	9. ESTIMATED DATE OF OBLIGATION A. INITIAL FY 78 B. QUARTER 2 C. FINAL FY 83 (Enter 1, 2, 3, or 4)
------------------------------------------------	-------------------------------------------------------------------------------------------------------------

A. FUNDING SOURCE	FIRST FY			LIFE OF PROJECT		
	B. FX	C. L/C	D. TOTAL	E. FX	F. L/C	G. TOTAL
AID APPROPRIATED TOTAL	4,225		4,225	39,535		39,535
(GRANT)	4,225		4,225	39,535		39,535
(LOAN)						
OTHER U.S.						
HOST COUNTRY						
OTHER COUNTRIES						
TOTALS	4,225		4,225	39,535		39,535

A. APPROPRIATION	B. PRIMARY PURPOSE CODE	PRIMARY TECH. CODE		3. 1ST FY 79		4. 2ND FY 80		K. 3RD FY 81	
		C. GRANT	D. LOAN	F. GRANT	G. LOAN	I. GRANT	J. LOAN	L. GRANT	M. LOAN
(1) PN	J460	460		4,785		5,200		8,441	
(2)									
(3)									
(4)									
TOTALS				4,785		5,200		8,441	

A. APPROPRIATION	N. 4TH FY 82		O. 5TH FY 83		LIFE OF PROJECT		12. IN-DEPTH EVALUATION SCHEDULED MM YY
	Q. GRANT	R. LOAN	S. GRANT	T. LOAN	U. GRANT	V. LOAN	
(1) PN	8,442		8,442		39,535		
(2)							
(3)							
(4)							
TOTALS	8,442		8,442		39,535		

13. DATA CHANGE INDICATOR. WERE CHANGES MADE IN THE PID FACESHEET DATA, BLOCKS 12, 13, 14, OR 15 OR IN PRP FACESHEET DATA, BLOCK 12? IF YES, ATTACH CHANGED PID FACESHEET.

NO
 YES

14. ORIGINATING OFFICE CLEARANCE		15. DATE DOCUMENT RECEIVED IN AID/W. OR FOR AID/W OCCU- MENTS. DATE OF DISTRIBUTION		
SIGNATURE	DATE SIGNED MM DD YY	MM	DD	YY
TITLE				

TABLE OF CONTENTS

<u>Page No.</u>	
1-2	Description of the Project (overall goal, sector goal, purposes)
2-5	Who Needs Training?
7	Who Needs to be Trained for What Family Planning Functions?
9	Summary of Family Planning Action Arenas and Technologies
11	In What Institutional Settings Should Paramedical and Auxiliary Personnel Training be Provided?
11-13	Where Should Training Take Place?
13-16	Major Instructional Content Themes
16-24	Training Service Agencies (TSA's)
22-24	Regional Training Service Agencies (RTSA's)
24-25	Specialty Training Service Agencies (STSA's)
25-28	Types of Services Supplied by TSA's
28-29	Qualification Criteria
29	Selection Procedures
29-30	Methods of Work
30-31	Work Authorities
30-32	Beneficiaries
32-33	Prospective Countries Where Project Would Provide Assistance
35	Program Outputs
38-45	Methodology and Results of Analyses
48-55	Financial Plan
55-58	Implementation Plan

TABLE OF CONTENTS (Continued)

59-60	Evaluation Plan for the Program
63-65	Evaluative Elements and Linkages
66	Logical Framework

LISTING OF CHARTS

Page No.

6	Chart I	- A Person or Team of Persons is Essential In Making Family Planning Available
8	Chart II	- Who Needs To Be Trained For What FP Functions
10	Chart III	- Summary of Family Planning Action Arenas, Technologies and Management Functions
19	Chart IV	- Components of the Training Service Agency (TSA) Model
21	Chart V	- Subject Matter Covered by this Training Program
23	Chart VI	- Interrelationships Between the Levels and Types of Training Assistance (Applicable to Governmental and Non-Governmental Agency)
26	Chart VII	- Program Organization Chart
34	Chart VIII	- Prospective Countries Where Project Would Provide Assistance
36-37	Chart IX	- Estimated Numbers of Eight Categories of Outputs
42-43	Chart X	- DS/POP/PI FY 79 Funding for Family Planning Training of Paramedical, Auxiliary and Community Personnel by Country
46-47	Chart XI	- Models of Previous TI Training Projects in Relation to the TSA Model
50	Chart XII	- Summary Cost Estimate and Financial Plan
52	Chart XIII	- Costing of Project Outputs/Inputs (In \$000 or Equivalent)
53	Chart XIV	- Estimates of How Resources Are To Be Applied
54	Chart XV	- Projection of Expenditures by Fiscal Year
61	Chart XVI	- Frequency of Profession by Region of 12,468 Persons Trained Internationally Between 1966-1977
62	Chart XVII	- Trainee Distribution According to Professional Background and Nationality
66	Chart XVIII	- Project Design Summary Logical Framework

GLOSSARY OF TERMS

CBD	Community Based Distribution
CRS	Commercial Retail Sales
HC	Host Country
IEC	Information, Education, Communication
MCH	Maternal and Child Health
NGO	Non-Governmental Organization
PAC	Paramedical, Auxiliary and Community Workers
P/FP	Population/Family Planning
TOT	Training of Trainers
TSA	Training Service Agency
RTSA	Regional Training Service Agency
STSA	Specialty Training Service Agency

2. Description of the Project

Overall Goal - Slow population growth in the developing countries to improve the health and well-being of the rural and urban poor and to protect the gains, real and potential, of modernization and development.

Sector Goal - LDC family planning and family health programs are providing protection from unwanted pregnancy for all families with women of reproductive age by making the information and means needed for family planning easily available and 65 to 70 percent of all couples are practicing family planning by effective means.

Purpose - To strengthen and expand LDC action agencies that provide or assist in making family planning services available, with emphasis on the rural and urban poor, by extending and enhancing the effectiveness of in-service training for paramedical (non-physician), auxiliary and community (PAC) personnel; by improving the capacity of relevant pre-service training systems; and by working to change those conditions that inhibit the willingness or ability of service systems to make maximum use of PAC personnel.

This centrally funded project is designed to meet three interlocking current needs of the population assistance program and the Agency for International Development.

- a. The urgent need that developing countries have, to make family planning information and services fully available to all their people including the poor majority in ways that are effective and are within their ability to bear the costs.
- b. The need of the Agency to be responsive to the specific Congressional instruction that significant sums of money be applied to the training of "paramedical and auxiliary personnel" to provide combined family planning services to the poor majority with special attention to rural areas.
- c. The need to manage a large and complex program with a very limited direct hire staff.

Analysis and study of these three needs has led to the strategy set forth in this Project Paper. The major principle upon which this project stands is to bring together all elements of Title X assistance, formally given to the training of Paramedical, Auxiliary and Community Personnel (PAC) through six previous projects, into a single coherent program that will provide managerial compactness, professional technical competence and adequate flexibility to meet needs that vary considerably from country to country and region to region and yet depend upon common principals and technologies. Under this program there will be, under a unified monitoring system in the Office of Population, several Training Service Agencies (TSA's) which will serve as intermediaries

to manage and provide the necessary assistance in the training and preparation of Paramedical, Auxiliary and Community (PAC) personnel for new or expanded roles in the delivery of low-cost categorical or integrated family planning (FP) services. The TSA's will be of two types: regional and speciality.

WHO NEEDS TRAINING?

Training resources are limited yet training has broad usefulness. The need for well trained health and family planning workers in developing countries is monumental. It is, therefore, necessary to sharply examine who needs the training for which this project is designed to provide, and to look at where it might be provided.

Definitions

A comprehensive listing of types of personnel that are considered to be "Paramedical" (a term much resented by many non-physician health professionals) and "Auxiliary" would include the following:

1. Paramedical - Non-physician professional (full world standard) and junior professional (intermediate standard) level personnel in the areas of:

- a. Midwives, Nurse/Midwives
- b. Nurses (Public Health, Community, FP Clinic, Surgical Clinic, MCH, Nutrition)
- c. Medical Assistants
- d. Training Officers:
 - 1) Planners and managers of training programs, and
 - 2) Skilled instructors for: Midwifery (cross trained), Nursing (cross trained), Auxiliary Personnel Development, and Community Workers paid and voluntary.
- e. Community Development Officers

2. Auxiliaries - Subprofessionals, Aides, Community Workers, "Barefoot Doctors", etc.

- a. Auxiliary Midwives
- b. Auxiliary Nurses, Nurses Aides, "Barefoot Doctors"

- c. Women's Health Care Specialists
- d. Community Workers
- e. FP Home Visitor-Field Workers
- f. Community Based Distribution (CBD) workers
- g. Managers, Trainers, Supervisors, Household Distributors, Supply Point People

3. Indigenous or Traditional Health Workers

- a. Traditional Birth Attendants
- b. Herbalists, Medicine Men, etc.

It is probable that in the course of five years of training, on the scale envisioned in this program, at least some people that fall into each of these categories will be trained. This is true because host country agencies, public and private, will be directly involved in defining who they want to have trained. However, it is an AID responsibility to analyze the probable relative effectiveness for its goals of the various classes of personnel and to set priorities for the TSA's to use as guidelines in providing training assistance.

The primary purpose of all Title X funded actions is to make it possible for LDC families in keeping with the U.N. Population World Plan of Action to have available the information and means that make it possible for them to have the number of children they want. The availability of information and means always involves a person or team of persons which require varying types and amounts of training depending on the delivery system and the family planning technologies that are being supplied. There are basically five independent classes of delivery systems that have significant roles in making the means of family planning available to LDC populations. They are:

- I. Self Help Systems - Where the individual receives non-surgical contraceptives from commercial sources without any professional medical intervention.
- II. Private Medicine - Where a private physician, for a fee, prescribes or supplies the relevant surgical or non-surgical methods.

- III. Community and Household Delivery (Community-Based-Distribution) - That make the non-clinical methods available directly to communities and households outside of formal medical delivery systems.
- IV. Primary Health Care/MCH/FP Systems - That provide surgical and non-surgical means in fixed or mobile, single purpose family planning or integrated health clinics, and health care centers frequently supported by governments but also including private agencies.
- V. Surgical Contraception Systems - Where surgical methods are supplied in hospital, outpatient or mobile surgical clinics, public and private.

In all five of these systems there are PAC personnel that are necessary for the functioning of the system. The classes of such personnel are shown in Chart I.

The ultimate goal of this program is to make it possible for these systems in all developing countries to be staffed with people who are adequately trained and motivated in the population/family planning knowledge and skills that are necessary for the particular services they perform. All of these systems, or as many of them as exist in any given country, are needed if 65 to 70 percent of fertile couples are to practice family planning. This is the level of practice which must be attained if population growth is to be checked to give optimum improvement of health and development that elevates the quality of life, especially for the poorest segment of the population.

While the primary focus of this program is the training of PAC personnel it should be recognized that in many countries there is a consistent process that it must also address before maximum utilization of such personnel in "coverage oriented" family planning programs can be accomplished. This process entails the consciousness raising tasks yet to be done with top government officials, leaders in the medical and nursing profession, elitest leaders in the society and community organization leaders that a) acquaints them with the nature of the problem, and b) prepares them intellectually and operationally to be supportive and involved in the kinds of program action this paper implies. Some of the most effective actions of this program will be the sponsoring of short courses, seminars, workshops and observation travel for policy leaders so the overall objectives of PAC training can be accomplished.

System IV, (Primary Health Care/Maternal and Child/Health/Family Planning; usually government operated) is the system which most people have in mind

when they think of health or family planning service delivery; the use of paramedical and auxiliary personnel; or "integrated" services delivery systems. Family planning started with this system (frequently beginning in the private sector and spreading to the public sector) in most countries. It is an extremely important system. In most countries there is still great need for FP knowledge and skills. Indeed there are many thousands of health care centers which do not provide family planning services. In this system, as the boxes in Chart I demonstrate, there is the widest variety of paramedical and auxiliary personnel utilized. Furthermore, this system is the most likely to have a clearly defined training program with some kind of permanent organization and facilities. The improvement of training in this system is a major objective of the program presented in this Project Paper. Yet even with full use of System IV at a high level of effectiveness there is no way that 65 to 70 percent of fertile couples will be reached and given the opportunity to practice family planning, principally because in most countries this system does not service that large a proportion of the population.

System III, (Community Based Distribution (CBD)), is now beginning to supply family planning services to large numbers of people. Up to now, in most countries, this system is present only in an experimental stage, however, in a few it is beginning to attain national coverage. A key characteristic of this system is that it deals with pills and condoms which can be distributed outside the conventional health care system yet at the same time can feed into a conventional system via referral when applicable. Further these services can be provided by people who require only limited training, which, at least in the beginning, can be supplied in a very short time.

In any case the rapid expansion of CBD to national coverage levels implies a large training need. One of the most significant challenges which will face the TSA's in this program will be the development of specific needs assessments, plans and programs designed to determine precisely what training CBD operations require and move to supply those requirements. The total numbers of people needed when country coverage is achieved is quite large. The training will have to be done, or at least renewed and sustained, as on-the-job training with trainer/supervisors doing much of the training.

System I, (Self Help), requires people who have to be trained in professional pre-service schools (pharmacists) or who function in the commercial sector. This program will not become actively involved in training these commercial sector people. At present such training is supplied by other contractors who are introducing CRS operations. TSA's, however, will need to keep informed about CRS operations and training as the training substance is similar. They also should be prepared to sponsor some of this training in countries before more formalized CRS activities are developed.

CHART I

A PERSON OR TEAM OF PERSONSIS ESSENTIAL IN MAKING FAMILY PLANNING AVAILABLE

<u>System</u>	<u>Non-Surgical Methods</u>	<u>Surgical Methods</u>
I. Self Help	Pharmacists, CRS Salepersons, Other Commercial Sales Persons	_____
II. Private Medicine	Private Physician Team Nurses, Aides	Private Physician Team Nurses, Aides
III. Community and Household Delivery (CBD)	Trainer/Supervisors, Distributors, Supply Point People	_____
IV. Primary Health Care/MCH/FP	Auxiliaries, Women's Health Care Specialists, Traditional Birth Attendants, Midwives, Nurses, Training Specialists, Social Workers	Nurses, Midwives, IUD Surgical Team (Surgical Contraception) Nurses, Aides
V. Surgical Contraception	_____	Surgical Team Nurses, Aides

Code:

Non-Physician Personnel That Require Some Degree of Training

Systems II, (Private Medicine) and V, (Surgical Contraception), use paramedical and auxiliary personnel who, for the most part, will have to get their training in the pre-service institutions which supply them to these systems. This, coupled with the need to train future System IV personnel at the pre-service level, defines a clear need to get the teaching of P/FP knowledge and skills introduced into the curricula of all pre-service training institutions on a permanent basis. This is a big task since most such institutions still have little or no teaching of P/FP material.

WHO NEEDS TO BE TRAINED FOR WHAT FAMILY PLANNING FUNCTIONS?

Chart II presents another way of looking at who needs to be trained. This matrix emphasizes family planning functions versus level of training showing two levels of professional and three levels of auxiliary community personnel types.

At present there are a number of examples of family planning functions being performed by nursing, midwifery, social work, training health education, CBD, and CRS types of personnel. The mix of these functions and the professional level and training of those who are performing them vary considerably from country to country. Each of the RTSA's will need to examine the actual and potential situation in countries where they propose to assist training operations, against this kind of a matrix. Within each box of the matrix, it will be necessary to critically analyze the requirements, effectiveness and costs that relate to the use of personnel represented in that box. The substantive program recommended and supported in each country should focus on those functions and types of personnel which in each case are determined to be of and most likely to be effective with due regard to the present state of readiness of leadership and institutions in the country to cooperate with the decided upon programs. It may be necessary in specific situations to accept mixes of activities that are less than ideal from AID's view point in order that the agreed upon program will, indeed, be enthusiastically accepted by the host country leaders and institutions and so obtain full support in implementation.

WHO NEEDS TO BE TRAINED FOR WHAT FAMILY PLANNING FUNCTIONS?

<u>FAMILY PLANNING FUNCTIONS</u>	<u>FULL PROFESSIONAL</u>	<u>JUNIOR PROFESSIONAL</u>	<u>AUXILIARIES</u>	<u>COMMUNITY PEOPLE</u>	<u>TRADITIONAL HEALTH PEOPLE</u>
Nursing: (Public Health, Community, FP Clinic, MCH, Nutrition, Surgical)	B.A./RN Surgical Nurse	RN	Women Health Care Specialists Nurse's Aides FP Home Visitor Field Worker "Barefoot Doctor"	Health Volunteer	Herbalist or Medicine Man
Midwifery	Nurse-Midwife	Midwife	Trained Birth Attendant	_____	Traditional Birth Attendant
Social Work	Social Worker M.A.	Social Worker B.A.	Social Work Aide	Volunteer	_____
Training	Training Manager	Training Specialist	Training Aide	Community Leader (Paid and Volunteer)	_____
Health Education	Health Manager	Information Officer	Information Worker	Volunteer	_____
Community Based Distribution (CBD)	_____	_____	Area Manager/ Supervisor	Supply Point Distributor	_____
Commercial Retail Sales (CRS)	_____	_____	Distribution Manager	Storekeeper	_____

SUMMARY OF FAMILY PLANNING ACTION ARENAS AND TECHNOLOGIES

Chart III presents the basic matrix of the essential family planning actions which should have clear priority in the implementation of this program. Here the emphasis is focused on what services are to be provided in what kind of locations. The matrix under Technologies presents all possible technologies that a given country might choose to supply in the type of clinic or organization indicated. Of course, it is clear that AID resources cannot be used to assist abortion for family planning. In planning sharply focused programs of training, this Chart should be of use for assisting the TSA in stripping off the nice-to-know or somewhat marginal training that would be good but is not necessary to achieve the primary purpose of improving the effectiveness and efficiency of family planning.

Although the primary purpose of this program is to train cadres of family planning workers it will also attempt to integrate training activities within other content areas and general health programs. For example this project will address training in the family planning component within closely related subject areas as maternal and child health. Special care will also be taken to integrate each TSA's efforts, whenever feasible or appropriate, with general training assistance and health actions A.I.D. and other international donor agencies are providing in other important areas. Avenues of flexible and joint funding arrangements will need to be examined and explored within these broader A.I.D. and donor programs.

SUMMARY OF FAMILY PLANNING ACTION ARENAS, TECHNOLOGIES, AND MANAGEMENT FUNCTIONS

ACTION ARENAS	HEALTH SERVICES SYSTEMS		COMMUNITY
	SURGERY CLINICS	HEALTH CLINICS *	OUTSIDE FORMAL HEALTH ORGANIZATIONS*
Specific Locations	Medical School Hospitals Teaching Hospitals Outpatient Clinics Fixed and Mobile	Primary Health Centers Secondary Health Centers Health Posts	Community Based Distribution Systems (Cities, Towns, Villages, Households) Commercial Retail Sales (Community Outlets)
Technologies	Sterilization Menstrual Regulation ** Abortion** IUD's Counselling Management of Side Effects and Sequelae	IUD's Orals Injectables Condoms Counselling First Stage Management of Side Effects and Sequelae	Orals Condoms Information Supplemental Health Medications
Management Functions	Supervision Reporting Logistics People Supplies Information	Supervision Reporting Logistics People Supplies Information	Supervision Reporting Supply Logistics

*Perhaps linked as in Indonesia.

**Training for this system not to be supplied by this project.

IN WHAT INSTITUTIONAL SETTINGS SHOULD PARAMEDICAL AND AUXILIARY PERSONNEL
TRAINING BE PROVIDED?

A. Service organizations public and private

1. Family planning. MCH/family planning, primary health care
2. Community organizations that can mount community based distribution systems.

In these settings the program will assist with leadership and management training, faculty development, and technical assistance for population family planning content through: (a) short courses (topping off), (b) on-the-job training, (c) refresher training.

B. Policy and standard setting agencies and professional associations.

In this setting the program will work for modification of service and training policies, standards and qualifications for the use of paramedical, auxiliary and community personnel to provide family planning information and services, and provide leadership and attitude change training.

C. Pre-service training.

In this setting the program should assist health training institutions by curriculum development, faculty training, teaching methods and materials development.

In each country, an analysis must be made to determine priorities and talents between these various settings.

WHERE SHOULD TRAINING TAKE PLACE?

The optimum location of training splits into a number of categories depending on the nature of the personnel being trained, the functions that are to be trained for and the languages which the trainees are equipped to use. For this analysis we can divide family planning personnel

into three categories: auxiliary, paramedicals and advanced paramedicals.

Auxiliaries must be trained in-country and should be trained as close to service location as possible. They must be trained in-country because most of them have minimal educational backgrounds and will not command a Western language to a level that permits them to study outside of their home country. The whole purpose of developing and using auxiliaries is to make use of the primary school graduate who is rooted in the community and who can do important work at cost levels which the community can afford to support. Auxiliaries can be divided into three categories.

1. Community Auxiliaries - CBD, Household Visitors - Field workers
2. Specialty Auxiliaries, Midwifery Aides, Nurses Aides, Women's Health Care Specialists, "Barefoot Doctors:
3. Traditional Health Workers - TBA, Herbalist, Medicine Men

Providing effective assistance for the training of auxiliaries through this project constitutes one of the major challenges for new and experimental ways of tackling the problem. An important activity of each TSA will consist of needs analysis and country by country planning to find ways to apply resources and leadership to train these classes of personnel. The actual training will need to be carried out in organized courses most of which need to be located in fairly remote areas to provide training as close as possible to the working location where the personnel trained will serve. The other major mode of training must be on-the-job training. On-the-job training requires the development and placing of leader/supervisors in positions both specially and organizationally that permit them to set up and maintain a consistent, continuing, on-the-job supervisory/training effort to help auxiliaries continue to grow and to develop skill in applying the knowledge that they have acquired through training, to the actual day-to-day services they provide individuals either in formal or informal frameworks. Clearly the major training function in this as in other areas of the project will be carried out by host country institutions with the TSA assisting in the identification of needs and program planning, providing some technical assistance and arranging financial support.

Paramedicals - Midwives, nurse-midwives, nurses (public health, community, family planning clinic, maternal and child health, nutritional, surgical) medical assistants, training officers, community development officers.

Training for these classes of paramedical personnel will take place in two frameworks:

- A. Topping off makeup training, and
- B. Pre-service Training.

Topping off training, which is essentially makeup to add the special knowledge of population and family planning material to already trained individuals, who got through pre-service training without receiving it, will take place within special short courses located either at the country or the regional/third country level and through on-the-job training.

Pre-service training will need to be implemented at the country level in the existing pre-service training institutions that are already turning out the paramedical personnel that the country uses. There needs to be effort in making improvements in these basic pre-service training systems depending upon the state of development of the country.

Advanced professional training is designed to train the leaders and teams of trainers who will impact on and manage the systems already outlined for auxiliaries and paramedicals. We have considerable experience with this kind of training. It has been done effectively by bringing teams to special training sites in the United States or in third countries. An important analytical and change aspect of this program over the next five years will be a careful reassessment of how much training will need to be continued in the United States, what kind it should be, how it should be modified and developed to meet changing needs with careful attention to the development of possible regional ad hoc or more permanent training centers where this more advanced professional training can be supplied.

MAJOR INSTRUCTIONAL CONTENT THEMES

As a result of the extensive work already done in training non-physician and auxiliary personnel for family planning and related family health work in all types of service delivery systems the principal subject matter themes which should be addressed when appropriate in such training programs have been identified to include the following:

1. Family planning (reproductive health) is a health program of equal importance with immunization, nutrition and sanitation in its impact on family health and human well-being.
2. Successful family planning programs need to be able to offer families all safe and effective fertility planning methods.
3. A predominant principle of family planning is that all of these methods must become fully available and accessible to the entire population.
4. To serve entire populations family planning services will have to be provided through all types of health and community services and outreach systems, to include Community Based Distribution and the use of traditional systems.
5. Understanding of risks of each FP method must include specific knowledge of the relative risks of the method in relation to the risks of too early, too frequent, or excessive or too late childbearing under the specific maternal health care conditions of the region where comparisons are made.
6. All types and levels of FP and health workers should be trained to the appropriate level of knowledge and skill required to counsel clients within the service delivery framework where they work.
7. The clinical training for each method should include:
 - a. Mode of action
 - b. Use effectiveness
 - c. Client management (information, education, screening for method, how to use method, etc.)
 - d. Contraindications
 - e. Side effects and complications
 - f. Management of side effects and complications
 - g. Follow-up
 - h. Referral

8. Functional and programmatic differences between family planning technologies used in the nonclinical framework and those used in the clinical framework need to be distinguished as well as the interdependence of one framework upon the other, i.e. referral of severe side effects and complications of nonclinical to clinical services.
9. In addition to having the training courses be living examples of effective training methods and procedures, time should be given specifically to teaching good training methodology so trainees will be effective trainers as the principle strategy of this program is to improve developing country training systems through trainer development supported by follow-up technical assistance.
10. Clinic organization and management is needed to thoroughly saturate all primary health care operations with family planning seen as an important cutting edge of family health improvement.
11. Importance of showing respect and consideration for family planning clients so as to effectively encourage continued use, and establish relations that help clients deal with method side effects or switch to another method compatible with special needs of the individuals. A primary consideration is to remove all unnecessary hinderances such as class difference between supplier and client, waiting time in crowded curative facilities, medicals exams, lengthy education of programs for clients not needing or wanting the information, registration forms that require unneeded or embarrassing information, etc., that stand between the client and easy access to necessary information and service.
12. Taking into consideration the biomedical definition of reproduction that deals with the medical risks of pregnancy such as the desire to defer pregnancy until the 20's, space pregnancy during the 20-30 decade, under ideal circumstances not have more than three pregnancies and two live births, and to terminate fertility when a family of two-to-three or a desired number is achieved, also being cognizant of the right of any couple to remain childless if they desire.
13. the concept that all teenage pregnancies are undesirable pregnancies from a medical point of view.
14. Community based distribution systems, principles of organization and operation, current experience with operations, reliable logistics and pipeline for the constant availability of pills and condoms, research on them, and what training and supervision needs this will entail.

15. The necessity for planning and managing all service systems on a cost effective basis with strict attention to the leadership and supervision that is required to sustain good quality service and high personnel morale.

16. The principles, experiences and role that social and commercial marketing plays in distribution of nonclinical contraceptives needs to be considered in relation to other modes of nonclinical distribution.

17. In addition to client education within both clinic related and community based services, the need to have an effective, sustained information and education program for the community that:

- a. Provides information about where and how to get services.
- b. Provides information about the various methods showing their high degree of safety and dealing with rumors and misinformation.
- c. Shows what the advantages of spaced and limited births are in terms of family security, economics and health.
- d. Shows what the social and economic advantages of slowed population growth are to the community, nation and world.
- e. Establishes the cultural and social acceptability and legitimacy of family planning and of the smaller family.

TRAINING SERVICE AGENCIES (TSA's)

The scope of work in assisting the training of the various types of personnel needing training as discussed above will be carried out by several Training Services Agencies. A Training Service Agency (TSA) is a centrally funded intermediary with demonstrated professional competence in the field of PAC training and also equipped with the necessary management and supervisory capabilities to be able to organize and support a wide variety of training activities in host countries, third countries and the U.S.

As outlined in Chart IV each TSA has these two distinct component parts that when utilized in combination can handle large numbers and varying levels of requests for training assistance within the four

major family planning content areas. The first component of the TSA model (Chart IV) is a management and supervisory capability that can provide the following three levels of training assistance to PAC personnel. The level of training assistance chosen for each situation will depend upon the identified training needs and the existence and quality of training activities currently being performed in host countries. In countries where there are little or no trained family planning personnel, the type of assistance needed will most likely be implementation assistance where participants attend a formal training course provided either directly by the TSA or through an established third country or U.S. training program. A major portion of this training will include training of trainers and training program development with the understanding that graduate trainees return to their respective countries and/or organizations and set up their own training programs.

The second level of training assistance provided by the TSA (as indicated in Chart IV) will be to assist host country trainers and family planning institutions with technical assistance and consultation in the planning of their own training programs. In this case the TSA would not directly assist in the implementation of the training but rather serve as an advisor in curriculum development and program design supplying the needed training materials and assuming the responsibility for monitoring and evaluating the training program.

The third level of training assistance provided by the TSA will be to provide monetary support to established in-country or third country training programs through a subcontracting arrangement. Here again the TSA would have direct responsibility for monitoring and evaluating the activities carried out under the training program. In this case host countries or third countries already have a family planning training program in place but lack the monetary resources to implement or sustain their planned training programs on a large enough scale to impact on the country's family planning programs through the provision of trained family planning workers.

These three levels of training assistance are progressive with the end result being that host countries have enough trained key personnel to plan for, implement and fund their own training programs. When countries reach the third level they will no longer need direct TSA training assistance but may possibly require continued monetary assistance to provide training.

The second component of the TSA model (as indicated in Chart IV) requires that each TSA have an experienced training staff that are able to directly provide PAC training in one or more the four family planning training areas covered by this project. That is, the TSA will be able to implement an entire training program itself whether it be in the U.S. or in host countries. Adherence to this qualification assures that each TSA will be fully knowledgeable in the training field.

It is always preferable for a host country or third country to be able to implement their own training programs, and this is a major objective of this PP, however in the early stages of training assistance in an LDC this is not always possible, and U.S. training may be needed.

Components of The Training Service Agency (TSA) Model

<p>Categories of Personnel to Receive Training</p>	<p>Management Capability to provide following types of assistance:</p>	<p>Professional/Technical Competence in directly providing at least one of the following training activities:</p>	<p>Categories of Personnel to receive training</p>
<p>Policy Makers PAC Trainers Paramedicals Auxiliaries Community Workers</p>	<ol style="list-style-type: none"> 1. Implementation 2. TA/Consultation 3. Monetary 	<ol style="list-style-type: none"> 1. Technical skills 2. Pre-service preparation 3. Management/Supervision 4. Training/Trainers 	<p>Policy Makers PAC Trainers Paramedicals *Auxiliaries *Community Workers</p>

*Very little TSA involvement in the direct provision of training for these workers.

Thus this qualification is also advantageous from a cost-benefit point of view in that all direct assistance need not be subcontracted to other U.S. institutions.

Training content areas were thoroughly covered in a separate section of this PP, however in summary all family planning subject matter fall within four major content areas which are covered briefly, as outlined in Chart V. The first content area is technical skills which includes all knowledge and skills necessary to supply family planning services both clinically and non-clinically. A program to train midwives in clinical contraception is an example of this type of training activity. The second content area is pre-service preparation which includes curriculum development, family planning material preparation and educational methodology all needed to plan for the inclusion of family planning in initial and formal PAC training curricula. Assisting a school of midwifery to plan their curriculum to include family planning in their formal teaching program is an example of this type of training activity.

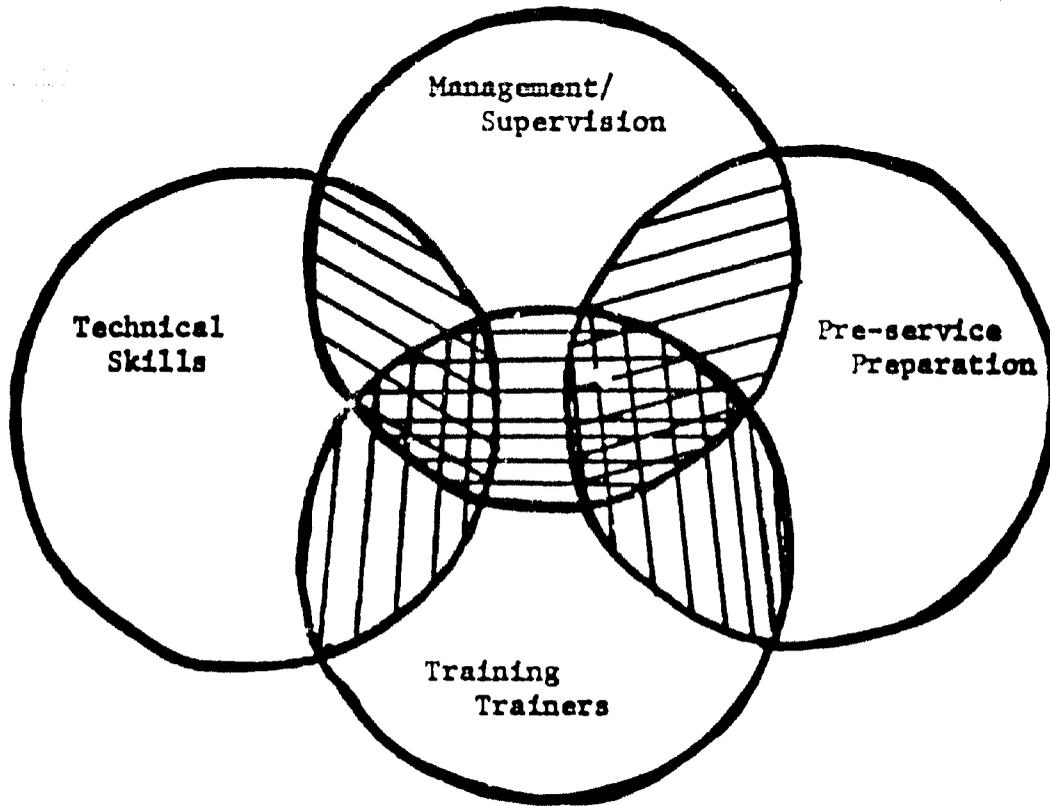
The third and fourth content areas are Management/Supervision Techniques and The Training of Trainers. For TSA's to provide training in family planning skills and pre-service preparation is not enough to tackle the great need of family planning manpower development in LDC's. Assuring that the delivery systems that trained personnel work in are effectively and efficiently managed is mandatory if family planning services are to be successfully provided. Therefore, skills in management and supervision are needed. Also a vital component to be a part of many training programs is to train trainers to train others (TOT) in both formal and informal settings. This assures the passage of information to others and enhances the multiplier effect of directly trained participants to actively attempt to train others.

A training program will often combine one or more of the content areas depending upon the category and job function of the trainee. It is for this reason, as shown in Chart V, that priority will be given to training categories of family planning personnel who will also be managers and supervisors and trainers of others. This is especially true when training middle management and top level management personnel.

Whether providing training assistance to a governmental agency or non-governmental agency, each TSA must put the identified training needs they plan to address within the context of the broader LDC organizational structure. Before vigorously training one cadre, the inter-relationships or part they will play within the larger organization needs to be analyzed. Training large numbers of midwives to practice family planning services may be futile, if for example, their direct

Chart V

SUBJECT MATTER COVERED BY THIS TRAINING PROGRAM



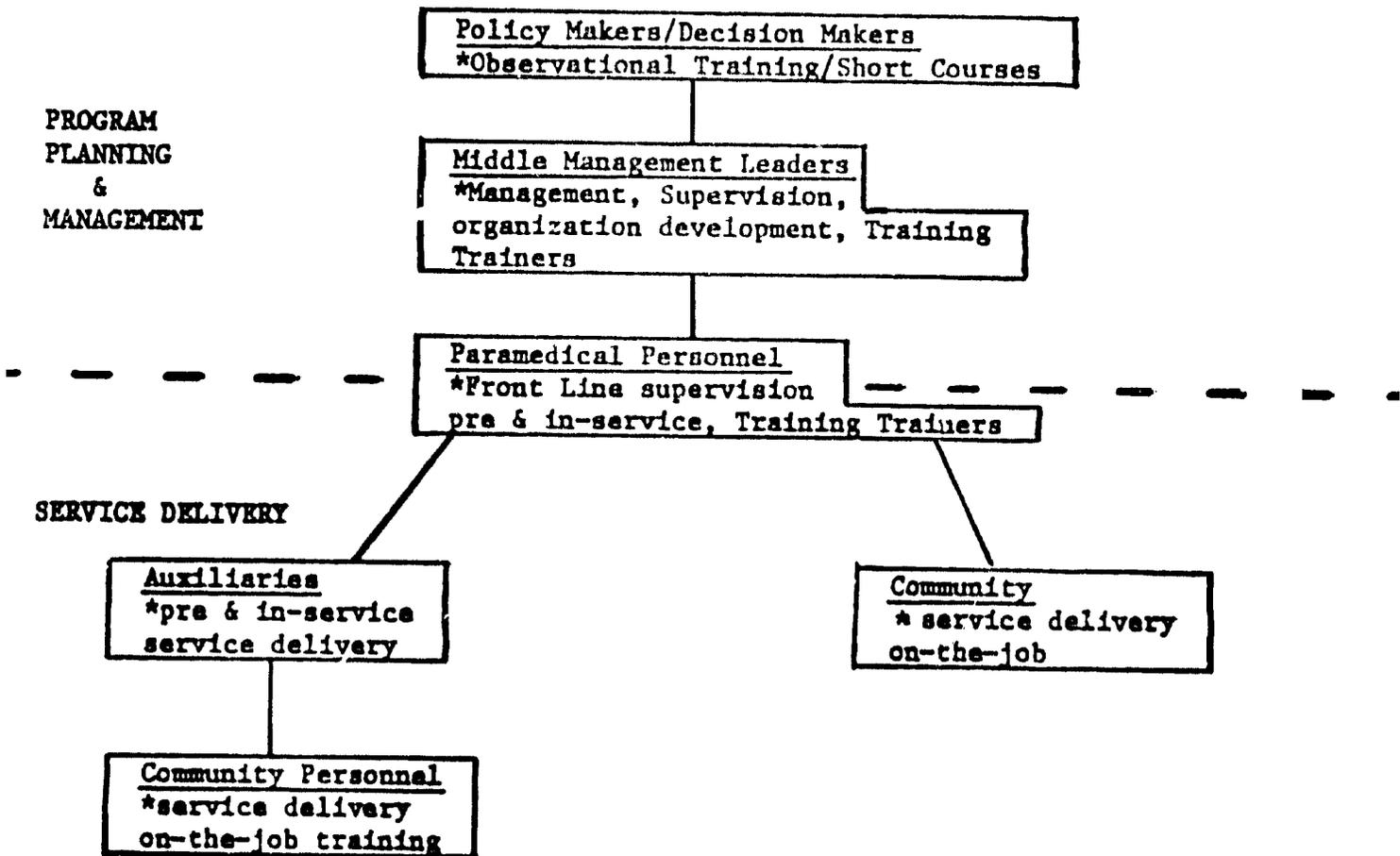
- high priority training

supervisors do not endorse or understand the objectives of their training. It is therefore, useful to draw up a training plan or strategy that will assure that all trained personnel will in fact use their learned skills. This is often a difficult task. Chart VI, attempts to look not only at the organizational interrelationships of personnel but also earmarks the family planning training requirements for each level of personnel to be funded under this program. This program is designed to train all categories of personnel from the top level policy makers in, for example observational training to visit a successful family planning training program in another country, down to the community based distribution workers in the provision of nonclinical family planning methods. This training project seeks to identify all levels of family planning training needs within a designated organization and will be able to provide the training requirements as indicated in Chart VI to all appropriate personnel within the targeted organizational setting.

a. Regional Training Service Agencies (RTSAs). There will be four RTSA's selected by appropriate procedures to insure compliance with competitive requirements. One each for Africa, Nena, Latin America and the Caribbean, and Asia. Each will have overall responsibility for assisting in the planning, implementation, evaluation, and coordination of training programs and activities for designated countries in their respective regions. Under the guidance of DS/POP, Regional Bureau monitor team and in close collaboration with AID Missions where they exist they would:

- 1) Assess country specific and regional PAC personnel family planning training needs and opportunities.
- 2) Plan with host country agencies, institutions and governments for the type and location of training.
- 3) Provide assistance, technical and financial, for implementing planned programs in accordance with host country needs, interests and available resources.
- 4) Collect relevant data for evaluating the results of training efforts in accordance with criteria established by the RTSA's, host countries and AID.
- 5) Coordinate training activities of sub-contractors, and other donors.
- 6) Work as liaison between AID/W project monitor and individual training and education sub-contractors.

INTERRELATIONSHIP BETWEEN THE
LEVELS AND TYPES OF TRAINING ASSISTANCE
(APPLICABLE TO GOVERNMENTAL OR NON-GOVERNMENTAL AGENCY)



Within each geographical region, there will be established a network system of offices and personnel which will promote maximum de-centralization of training efforts, and keep in close contact with ongoing activities and current needs. Dependent upon the specific area there may be for example: a U.S. - RTSA based office and staff, an overseas regional office and staff if necessary, sub-regional offices and staff if necessary, and host country staff. Requests for assistance will originate from the host country governments, private agencies, or AID Missions and will either go directly to the RTSA or through AID.

After planning with the appropriate host country counterparts and representatives, the RTSA in collaboration with other subcontractors or donors will plan the appropriate resources that could best meet a particular country's or institution's need. These plans will be developed with the collaboration of AID Missions, where they exist, and will be approved by the AID/W monitoring team before they are finally agreed upon and implemented.

b. Specialty Training Service Agencies (STSAs). In addition to the four RTSA's outlined above provision is also made for the selection of one or more Specialty Training Service Agencies (STSAs) to carry out specific and unique activities on a worldwide basis as will be determined to be required. An example of such an STSA is the International Confederation of Midwives (ICM) which currently in cooperation with the International Federation of Gynecologists and Obstetricians (FIGO) carries out the following functions:

- 1) Work with Host Country government and professional organizations to promote change in policies, procedures and standards in accordance with new and/or extended roles for paramedicals, auxiliaries and other related personnel so that they will be more acceptable and utilized within host country delivery systems - public and private.
- 2) Engage in activities related to promotion of awareness, IEC and other issues and activities related to the strengthening and expansion of HC/FP delivery systems in LDCs, through regional seminars, workshops and consultations.
- 3) Coordinate functions with the RTSA's so there can be follow up, with resources, on interests expressed by health care activities for training and education activities, and in some circumstances organize and implement training.

Organizational Relationship

The organizational relationships of the various Training Service Agencies which will be funded under the Project Paper to provide the outputs needed

to meet the purpose and to contribute to achieving the goal of this project are shown in Chart VII. The timing and extent to which the various sub-regional programs are set up and implemented will be worked out between each RTSA and AID through the request for proposals and related processes, by which they are chosen, with provision for modification over time as actual experience is accumulated.

Types of services supplied by training service agencies.

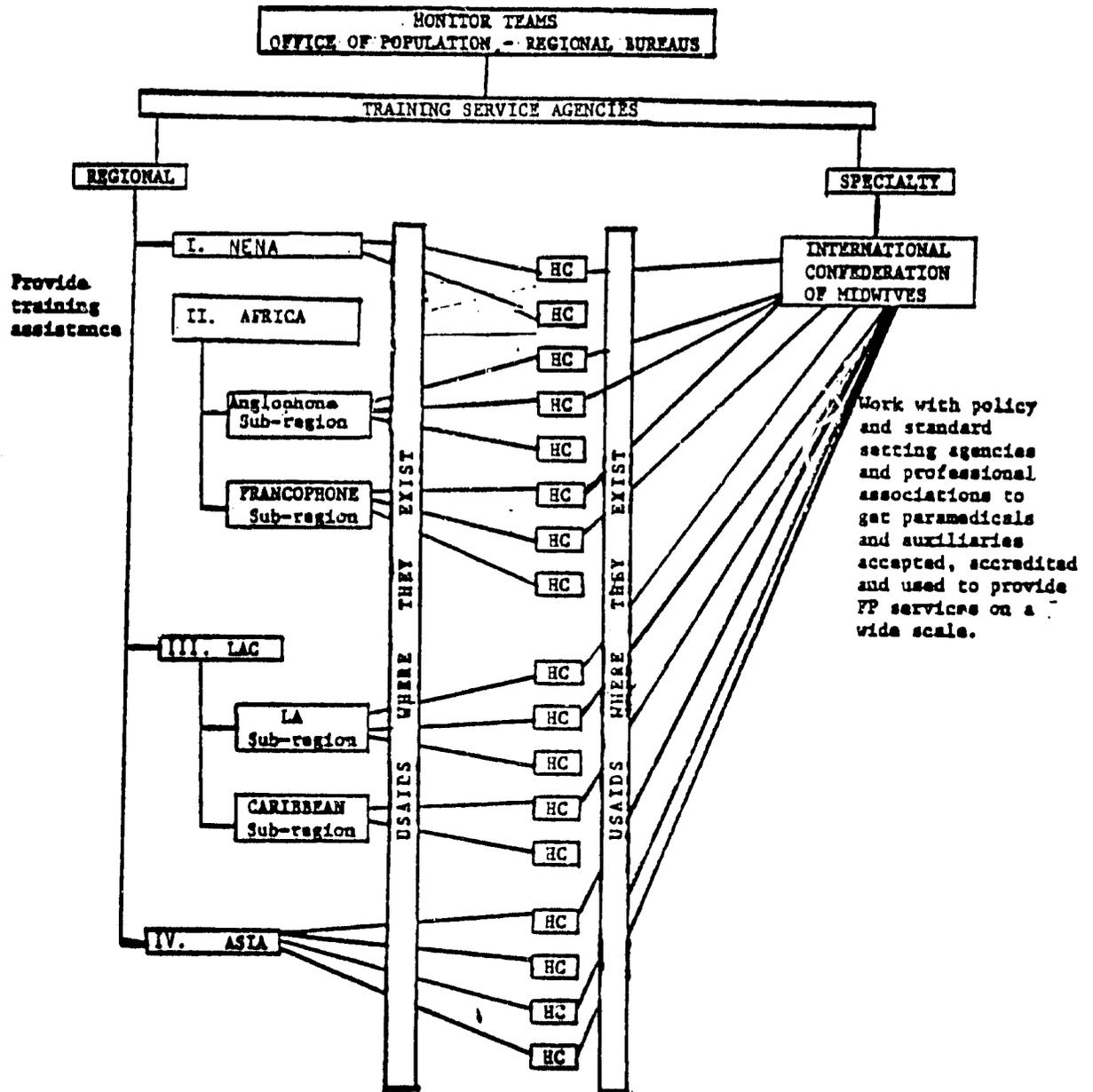
The training service agencies to be contacted with under this project will carry out action to supply the following types of services in achieving improvement of educational and training activities for the development of non-physician and auxiliary personnel in developing countries. The particular combination of services will be defined for each TSA in the light of the needs of either the region or the specialty which the TSA is to serve. The specific services are presented in rough priority order.

1) Technical assistance for in-country training programs and Institutions.

The activities of this program do not start at zero. A large amount of training directed at non-physician and auxiliary personnel is already being done in each developing country. Predecessor activities have already generated much improvement in existing training programs. A primary service to be rendered is to provide technical assistance for problem analysis, planning, and implementation to specific institutions and training programs in various countries. In providing this service the TSA will take care to build upon existing institutional foundations and avoid creation of new institutional foundations as far as is possible.

2) Faculty development through international training of trainers for selected students in selected subject areas. One major means for achieving effective training in developing countries, that has been thoroughly proven by past experience is selecting teams of trainers and providing for their thorough, effective, but short term, training in the U.S. or at other points outside of their own countries. The training programs planned for this purpose must be well rounded and quite specific in relation to the actual situation in the country from which the participants come. Such training programs should have plans for technical assistance follow-up and evaluation built into them from the beginning.

3) Financial support for in-country training programs. One of the major barriers to rapid improvement of training programs in developing countries is the lack of financial resources to pay for expansions or innovations which are to be introduced. The TSA will, therefore, be



Note: Whether sub-regional units are required will be determined at FIO/T stage in each case.

given authority to make subcontracts with LDC training programs to insure that the resources needed for the implementation of needed programs are in fact available. Each TSA will be able to subcontract to a series of institutions both U.S. and in-country. The use of local training institutions and indigenous training groups will be a priority. Subcontracts will generally be short term and for the most part will not assist in long term training or institution building. Each TSA will have to become expert in judging and implementing these subcontracts.

4) Preparation and use of educational materials. One of the most important actions of the program requires that specific, effective educational materials in a variety of forms will be prepared, translated into the necessary local languages and that teachers and trainers be taught to use them. Some of the training material must be country specific and emphasis will be given to helping host country institutions develop their own. Yet much material can be regionally developed with the primary local input being one of adaptation. Such training materials can go a long way toward sustaining the quality of the training process. All training programs must include skills training including the necessary clinical skills that are required for any specific technological combination. The TSA must, therefore, be able to generate, adapt, evaluate, and supervise the use of improved instructional materials and aides of all relevant types.

5) Curriculum change and development in pre-service institutions. For the most part this program is directed at short term training in action oriented organizations to make immediate impact on the competence and use of paramedical and auxiliary personnel for the supply, primarily of family planning and related supportive health services to large numbers of families. However, it is also necessary that the relevant materials that relate to population family planning be effectively incorporated into the relevant pre-service training institutions so that it will not be necessary to continue intensive short term "make-up" training in the future. The TSA's will, therefore, design relevant programs for achieving curriculum change and development in pre-service health and community training institutions to insure that population and family planning components with respect to knowledge, attitudes, and skills, are successfully introduced into the pre-service institutions that will be the long term providers of the personnel for health and family planning activities throughout the countries concerned.

6) Policy, Training and Use Standards for non-physician and auxiliary personnel. One of the major deterrants to the widespread use of auxiliary personnel to provide family planning and health services in the developing countries is the resistance of existing organizations and professional groups to their widespread use. A major task of this program is to work with ministries of health, professional associations and other relevant groups to change attitudes toward the use of these types of personnel.

A major thrust of this project will, therefore, include attention to this matter, with at least one important specialty TSA concentrating most of its attention on this activity, but with all TSA's being willing and ready to cooperate with efforts to get use of PAC personnel auxiliaries more widely accepted.

7) Consultative Technical Assistance. Many formal organizations including ministries of health and family planning service organizations both public and private have organizational, management and implementation problems with their training systems. An important service which each TSA must be able to provide is consultative technical assistance to help in planning for change and improvement in these various systems.

Qualification Criteria

To qualify for consideration as a TSA's under this program institutions must meet the following criteria:

- a) Be a professional, educational and training institution.
- b) Have high grade professional educational and training personnel with demonstrated organizational and training experience and skill.
- c) Have a proven institutional base that is recognized as superior in its achievement in education and/or training of non-physician and auxiliary types of medical and community personnel.
- d) Have financial/accounting and management capacity to handle and manage a large and complicated flow of funds to implement programs, monitor programs through joint planning and evaluation and subcontract and monitor training activities of established programs.
- e) Have extensive specific knowledge of and experience with the region or specialty for which it will work, including experience in working abroad in developing countries.
- f) Have a demonstrated ability to deal with the special needs and problems of international training activities with special attention to the individual and cross cultural requirements of working with developing country individuals and institutions.

- g) Have a strong commitment to the importance of family planning as a health and development subsector.
- h) Have a strong commitment to the training and use of PAC personnel in the direct provision of family planning and health services with strong emphasis on providing knowledge and services to entire populations, especially to the poor.

Selection Procedures

Each TSA will be selected by the application of the relevant federal procurement procedures, that will insure the examination and competitive evaluation of all potential entities which might be qualified to provide the required services with the purpose of obtaining the best result possible for the achievement of the purposes of the project. In the selection process, in addition to the Office of Population, suitable representatives of the Regional Bureaus and such other Offices of the Development Service Bureau as are relevant to the specific purposes of the individual TSA activity will be included.

Primary emphasis will be placed on the proven track record of the institution under consideration, the quality and effectiveness of the leadership it proposes for this program, and its scoring against the criteria listed above.

Methods of Work

Each TSA as a part of its proposed submission, will outline in detail the methods of work which it proposes to apply to the achievement of the objectives called for in the particular contract or grant. The principles governing the application of methods of work will include such things as:

- a) Designing courses to teach essential knowledge and skills in the shortest feasible time.
- b) Sharply focusing effort on immediate payoff results with emphasis on the selection and teaching of relevant materials with much emphasis on practice and doing both in clinical and community activities.
- c) The use of involvement teaching/learning processes with constant attention to making effective leaders/teachers of most trainees in order to amplify the multiplier effect to achieve maximum coverage and rate of expansion of effective knowledge, skill and ability to deliver practical services.

d) Constant attention to the development of institutional strength on the part of the developing country organization and institution with and through which the TSA works.

e) Constant attention to the development of institutional leadership quality among the developing country nationals with the intention of being able to withdraw support as rapidly as is feasible and still achieve a permanent institutional development and program effect in the country concerned.

f) Principally concentrating efforts on the development of permanent specific country training arrangements, but with intermediate use of third country or ad hoc multi-country activities where it is advantageous.

Work Authorities

Each TSA will be given appropriate authority to make sub-contracts with appropriate international and in-country institutions or agencies that are needed to carry out the purposes of the contract or grant. Such subcontracts will be put in force only after appropriate approval by the project monitor and the contracting office.

Each TSA will be provided appropriate authority to make subcontracts with host country institutions and programs. In order that specific resources can be immediately made available for the implementation of improved training programs, these subcontracts will be approved by the project monitor and the contracting office. Subcontracting for overseas activities will require processing of procurement source waivers. These source waivers will be processed at the appropriate time.

BENEFICIARIES

The basic strategy of this program is to radically expand the availability of family planning and associated health services into not-easy-to-reach rural and urban settings. This expansion is essential if the health and well-being of the poor majorities who reside in these difficult to reach localities are to be improved by providing the information and means they require to plan their families. Therefore, the primary beneficiaries of this program will be a vast number of poor majority families who, as a consequence of the increased availability of information and family planning services, will be able to improve their health, their social status and their economic well being by reducing the number of dependents whom they must provide for, and lowering the health risks involved with many repeated pregnancies and births. The project will reach these groups by vastly expanding the number and improving the quality of the auxiliary and paramedical personnel which are utilized in the five family planning delivery systems which have been outlined in a previous section. The availability of these types of

personnel in adequate quantity will lower the cost of providing these fundamental services as well as expand the number of points within both organized health delivery systems and in communities that are beyond where such systems now exist. Such expansion can happen only if: 1. decisions are made in the countries to expand the use of auxiliary and paramedical personnel, and 2. prompt effective training programs are mounted and carried through to train these expanded numbers of personnel including providing them with continuing supervision and on-the-job training to keep their morale and effectiveness at high levels. It is estimated that many tens of thousands of personnel will be trained during the five years of this project (See Chart IX, on Output Estimates).

A second major beneficiary group will be young women with basic, modern education whose opportunity for professional and subprofessional work will be expanded where the program is carried out. The overwhelming majority of the people who will be trained in this program will be such young women. This is particularly true of the community and auxiliary workers who will be chosen from those who have basic literacy and adequate general education to be able to take and utilize the training. At the community level there will also be a significant number of somewhat older women who have less education who will profit by this program. These women will be the natural leaders in their communities who will be trained as community based distribution depot and store owners/managers who will be chosen for their already attained community leadership characteristics and will be able to improve their social status and their economic well-being as a consequence of the earning which they will be able to make as modestly paid community distribution workers.

A third category of beneficiaries will be the more senior and better educated paramedical and auxiliary workers who will be given advanced training to improve their leadership and training skills so that they will be able to advance professionally in the various health and family planning providing systems. There will be several thousand people who will be upgraded, many of whom will achieve expanded opportunities as a consequence of the training and technical assistance which this project will give them.

The fourth beneficiary will be the pre-service and in-service training programs and institutions which this project will assist. These institutions, as a consequence of this program, should end up more well prepared to continue providing training and backup assistance for population and health activities long after this project is completed. They will have improved personnel, improved and adapted teaching materials and a significant accumulation of experience in how to organize for training and use of paramedical and auxiliary personnel including improved capacities to supervise and maintain growth through on-the-job and supervisory training techniques and processes. This program is designed with sufficient resources and specific guidelines to make it possible to sustain assistance to a large number of training activities in the developing countries long enough and with great enough detail and depth to institutionalize the improved processes it will be propagating into the systems of the countries so that they will remain as a permanent part of the medical health and community structures that these societies must have if they are to attain their health and development objectives.

This program is directly focused on the attainment of the sector goal of manpower and institutional development within the overall health/family planning goal of this sector. It will build upon a number of years of specific and practical experience with this kind of training already carried out. It should, during the course of the next five years, make it possible for a number of countries to progress with their training capabilities to the point that they can continue to meet their needs in the future without outside assistance. However, among the countries which have already indicated their interests and need in this area, there will be quite a few which are now so underdeveloped in their medical services and training areas that with all the efforts this program can make, they cannot be adequately prepared to meet their own needs without outside assistance in the next five years. It, therefore, seems highly probable that when this program is looked at in its global dimensions it may well need to continue to operate for a second or even third five-year period. However, by the end of this five-year period there should be quite a number of "graduate" countries which no longer need assistance.

PROSPECTIVE COUNTRIES WHERE PROJECT WOULD PROVIDE ASSISTANCE

In the spring of 1977 a circular airgram went to all AID posts throughout the world raising questions about the fields perception of needs to expand family planning training of paramedicals, auxiliaries and community personnel.

In response, most countries replied giving detailed reactions to the questions raised. As a consequence of the analysis of these responses (Chart VIII), 57 countries which were prospective users of the assistance this project would provide was compiled. Thirty-three of the countries replied that they would carry forward the training activities contemplated in this program principally through bi-lateral actions although in some of them there could well be assistance supplied to private agencies with governmental approval. A total of 23 countries have situations where no bi-lateral agreement exists or where general AID programs are largely shut down, or the government is not ready to enter into family planning activities. In these 23 countries this project would operate through private agencies by arrangements which would be officially or tactly approved with the governments concerned.

This list provides an extensive array of countries which, between them, have aggregate populations that represent a majority of the people in the developing world which AID can work with. Each of the regional TSA's would, in consultation with the Office of Population and the relevant Regional Bureau, carefully examine this list of countries adding to it or subtracting from it and arranging it by priority which would define the order in which action in-country and in subregion would be targeted.

PROSPECTIVE COUNTRIES WHERE PROJECT
WOULD PROVIDE ASSISTANCE

<u>Region</u>	<u>Bilateral</u>	<u>Nonbilateral</u>	<u>Total</u>
Asia	1. Pakistan 2. Bangladesh 3. Indonesia 4. Philippines 5. Thailand	1. Sri Lanka 2. India	7
Near East	1. Afghanistan 2. Jordan 3. Egypt 4. Tunisia 5. Morocco	1. Turkey 2. Syria	7
LA	1. Honduras 2. Peru 3. Dominican Republic 4. Haiti 5. Costa Rica 6. Jamaica 7. El Salvador 8. Guatemala 9. Bolivia	1. Colombia 2. Brazil 3. Trinidad & Tobago 4. Chile 5. Mexico 6. Ecuador	16
Africa	1. Kenya 2. Tanzania 3. Botswana 4. Lesotho 5. Swaziland 6. Ghana 7. Zaire 8. Senegal 9. Togo 10. CAE 11. Liberia 12. Sudan 13. Ethiopia 14. Mali	1. Benin 2. Gambia 3. Cameroon 4. Mauritania 5. Upper Volta 6. Niger 7. Chad 8. Zambia 9. Nigeria 10. Sierra Leone 11. Mauritius 12. Rwanda 13. Burundi	37

PROGRAM OUTPUTS

Overall the outputs of this program are eight as follows:

1. Training projects assisted
2. Nurse, nurse-midwives trained
3. Auxiliaries (nurses, midwives, TBA's) trained
4. Community (CBD and other) workers trained
5. Administrators, managers, officials, physicians trained
6. Paramedicals/auxiliary utilization policy and standards meetings held.
7. Training of trainers and training systems assistance provided
8. Curriculum development assistance provided.

Each of these outputs can be subdivided into several divisions as shown in Chart IX. Estimated Numbers of Eight Categories of Outputs.

The chart estimates both the numbers of persons trained or services provided in training projects or activities that are directly assisted by this program as well as those who, during the same period, would be trained indirectly by the directly trained people. This constitutes an effort to estimate, to some degree, the multiplier effect which this program should have and to set up requirements for the TSA's to arrange to keep data or make surveys to obtain data that would measure the multiplier effects which this training actually has. It is believed that the resources provided in this project would make it possible to mount training projects which in the course of five years would result in the training of approximately 150,000 LDC personnel. This quantity of personnel is in the order of magnitude of the need for family planning services expansion in the proposed target countries. It is of sufficient magnitude to have the potential of significantly improving the health and well being of the populations of the host countries and of assisting the processes by which population growth is slowed in ways that would be important to the improvement of the economic and social well being of the countries concerned.

ESTIMATED NUMBERS OF EIGHT CATEGORIES OF OUTPUTS

<u>OUTPUTS</u>	<u>CUMULATIVE NUMBERS</u>				
	<u>79</u>	<u>80</u>	<u>81</u>	<u>82</u>	<u>83</u>
1. Training Projects Assisted					
a. In-Country	15	25	35	50	65
b. Regional	3	5	7	8	8
c. U.S. (Wood)	3	4	4	4	4
	<u>21</u>	<u>34</u>	<u>46</u>	<u>62</u>	<u>77</u>
2. Nurses, Nurse/Midwives/Midwives Trained					
In Directly Assisted:					
a. In-country Projects	450	1,000	1,600	2,300	3,000
b. Regional Projects	90	240	450	690	930
c. U.S.	90	210	333	450	570
	<u>630</u>	<u>1,450</u>	<u>2,383</u>	<u>3,440</u>	<u>4,500</u>
In Indirectly* Assisted:					
a. In-Country Projects	2,000 ¹	5,000	8,000	12,000	16,000
b. Regional Projects	500 ¹	1,200	2,400	4,800	10,000
c. On-the-job	1,000 ¹	2,500	3,500	6,000	9,000
	<u>3,500</u>	<u>8,700</u>	<u>13,900</u>	<u>22,800</u>	<u>35,000</u>
3. Auxiliaries (Nurses, Midwife, TMA's) Trained					
In Directly Assisted					
a. In-Country Projects	1,500	3,000	5,000	7,500	10,500
b. On-the-Job	2,500	5,500	9,500	14,000	19,000
	<u>4,000</u>	<u>8,500</u>	<u>14,500</u>	<u>21,500</u>	<u>29,500</u>
In Indirectly Assisted:					
a. In-Country Projects	2,000	5,000	9,000	14,000	20,000
b. On-the-Job	3,000	7,000	12,000	18,000	25,000
	<u>5,000</u>	<u>12,000</u>	<u>21,000</u>	<u>32,000</u>	<u>45,000</u>

*Indirectly assisted projects are projects where graduates of directly assisted training programs provide second and third generation training pass on.

¹Includes indirectly trained individuals trained by trainers trained by predecessor.

	79	80	81	82	83
4. Community (CBO and Other) Workers Trained					
In Directly Assisted:					
a. In-Country Projects	300	700	1,200	1,800	2,500
b. On-the-Job	<u>3,500</u>	<u>8,000</u>	<u>12,000</u>	<u>16,700</u>	<u>20,000</u>
	<u>3,800</u>	<u>8,700</u>	<u>13,200</u>	<u>17,400</u>	<u>22,500</u>
In Indirectly Assisted:					
a. In-Country Projects	50	150	350	700	1,000
b. On-the-Job	<u>500</u>	<u>1,500</u>	<u>2,500</u>	<u>5,000</u>	<u>10,000</u>
	<u>550</u>	<u>1,650</u>	<u>2,850</u>	<u>5,700</u>	<u>11,000</u>
5. Administrators, Managers, Officials, Physicians Trained					
In Directly Assisted:					
a. In-Country Projects	50	100	225	350	500
b. U.S.	<u>50</u>	<u>100</u>	<u>225</u>	<u>350</u>	<u>500</u>
c. On-the-Job	<u>25</u>	<u>50</u>	<u>100</u>	<u>175</u>	<u>300</u>
	<u>125</u>	<u>250</u>	<u>550</u>	<u>875</u>	<u>1,300</u>
In Indirectly Assisted:					
a. In-Country Projects		50	100	150	200
b. On-the-Job	-	<u>25</u>	<u>50</u>	<u>100</u>	<u>200</u>
		<u>75</u>	<u>150</u>	<u>250</u>	<u>400</u>
6. Paramedical/Auxiliary Utilization Policy and Standards Meetings Held					
a. Regional (No.) Attendees	(5) 150	(8) 240	(10) 300	(12) 360	(14) 420
b. Country (No.) Attendees	<u>(12) 240</u>	<u>(24) 480</u>	<u>(36) 720</u>	<u>(48) 960</u>	<u>(55) 1,100</u>
	<u>(17) 390</u>	<u>(32) 720</u>	<u>(46) 1,020</u>	<u>(60) 1,320</u>	<u>(69) 1,520</u>
7. Training of Trainers and Training Systems Assistance Provided					
a. Country (Sessions) Attendees	(3) 90	(6) 180	(9) 270	(12) 360	(15) 450
b. Regional (Sessions) Attendees	<u>(2) 60</u>	<u>(4) 120</u>	<u>(6) 180</u>	<u>(8) 240</u>	<u>(10) 300</u>
	<u>(5) 150</u>	<u>(10) 300</u>	<u>(15) 450</u>	<u>(20) 600</u>	<u>(25) 750</u>
8. Curriculum Development Assistance Provided					
a. Consultations	20	35	50	65	80
b. Workshops and Conferences (No.) Attendees	(55) 250	(10) 500	(15) 750	(20) 1,000	(25) 1,250
c. Materials Developed (No. Titles)	25	50	60	70	85
d. Materials Distributed (Pieces)	<u>50,000</u>	<u>150,000</u>	<u>225,000</u>	<u>350,000</u>	<u>500,000</u>

These numbers represent crude global estimates which will be refined in the several FIO/Ts and in the TSA's needs assessment studies.

3. METHODOLOGY AND RESULTS OF ANALYSES

a. Economic Feasibility

The calculation of the economic feasibility of training for family planning and related health activities is doubly complex. It includes the difficulties involved in estimating the economic return on educational activities, i.e. training and the difficulties of estimating the returns on family planning, i.e. the economic advantage of births prevented under conditions of already achieved population surplus with varying but high degrees of unemployment and in many situations underemployment. There have been a number of attempts both theoretically and empirically to determine the cost/benefit of births prevented under the economic and social conditions in developing countries. These studies have produced a range of estimates as to the cost/benefit of a birth averted. They range from \$15 to \$20 to more than \$100 saved by families and communities per birth averted for each \$1 spent on family planning to prevent births. Approached in another way it has been estimated that in a country like Bangladesh which has a percapita GNP of about \$100, each birth averted saves the family and community about \$750 in health, food and clothing, and educational costs to raise the child to age 10 years. This means that the prevention of 1,000 births saves the community \$750,000. If a birth can be prevented for \$50 (Data from many countries indicates that family planning costs per birth averted range from \$5-6 to \$30-50, depending on country and method) then the community has gained \$700,000 in savings for a cost of \$50,000, giving a cost benefit ration of 14. There is data to support the estimate that the expenditure of the first \$1 billion by AID for population and family planning has played a significant part in the prevention of more than 20,000,000 births. (The AID costs may have been from 50% to 75% of the total cost). If the saving per birth is conservatively estimated for all countries as that in the poorest countries like Bangladesh at \$750 then the aggregate saved thus far might well be in the order of \$15,000,000,000. This would indicate a conservative cost benefit ration of 15 to 1. The total training funded by AID and its contractors and grantees has run about 15% of the first \$1,000,000,000 spent on the program. This would mean that \$150,000,000 has been spent for all types of training. At the general 15 to 1 ration shown above the training effort (assuming equal effectiveness) would account for a savings of \$2,250,000,000.

However, conservative and rough these estimates are they strongly support the conclusion that birth prevention expenditures including those for training are among those which have the highest rate of return of any type of development expenditure.

There are considerable economic advantages in conducting PAC personnel training in the country where the trainee serves. The current normal cost per trainee who is brought to the U.S. for short term training runs from about \$6,000 to as much as \$8,000 per trainee. If the target estimates for both costs and number of trainees estimated in Chart XIII are in fact achieved, the cost per paramedical trainee directly trained by the program will be about \$2,000 and those indirectly trained will be only \$20 with an average of \$260 for both directly and indirectly trained paramedics. Comparable figures for Auxiliaries will be \$490, \$13 and \$110. For Community workers they will be \$350, \$10 and \$135. For Administrators and Physicians they will be \$1,800, \$40 and \$783. The training for quantity indirect training is strongly emphasized by these estimates.

b. Social Soundness

The expanded use and improved operational quality of health and family planning services delivered as a consequence of the training of paramedical and auxiliary personnel assisted by this project will clearly impact directly on the quality of life of hundreds of thousands, perhaps millions, of poor majority families. There is extensive evidence from the operations of family planning programs in several scores of LDC's that shows that the multiplication of the points in all types of health/family planning service delivery systems at which high quality services are supplied results in the increased acceptance and continued use of family planning. Both the increase of service points and the improvement of quality of service is directly dependent on the training of paramedical and auxiliary personnel who operate those delivery systems. It is also quite clear that the health and well-being of families which space and reduce the total number of births they have is much enhanced so that all of the basic quality of life standards which AID seeks to foster for the poor majority are enhanced as a consequence. These considerations relate to the ultimate beneficiaries - the poor majority.

The more direct beneficiaries of this program, young and middle aged community women who will be trained as auxiliaries and the more senior professional non-physicians who will be advanced in their leadership, administrative and training skills, will quickly and powerfully enhance their status and expand their economic and social opportunities. They will expand the reality and perception of the opportunities which women have for growth, self-realization and participation in modernizing activities. These changed role opportunities will in turn impact on community attitudes toward women and will promote the acceptance of smaller families as the desired norm of the community.

The impact of this program on pre-service and in-service training institutions will also have social effects that are highly desirable for the whole modernizing process. A major emphasis will be on keeping training lean, focused on well identified needs and completed in minimum time periods so as to lower costs and enhance the rate at which adequate numbers of trained people can be put into place. This approach should serve to greatly improve the educational efficiency of the institutions concerned.

At all levels, this program is sound in concept and is socially acceptable and conducive to fostering social change in directions that are desirable and are life quality enhancing. This program is therefore, socially sound and development fostering.

c. Technical Feasibility

The basic organizational concept of this program, namely that a centrally funded agency can effectively stimulate, provide technical assistance and resource support to regional and in-country training systems and institutions, is technically feasible. It has been demonstrated to be effective and efficient through a whole series of similar projects, i.e. for physicians - the Program for International Education in Gynecology and Obstetrics; for social workers - curriculum development program for schools of social work completed by the International Association of Schools of Social Work; for Nurse Midwives - the Downstate New York program for clinical training for Nurse Midwives; across the board for a whole region - the Development Associates program of training for Latin America.

The instructional methods and technologies are all well tested and proven to work well in the U.S. and in the developing countries. Furthermore, LDC personnel already trained in earlier stages of this activity and by other agencies are in place in a wide variety of institutions and situations to be used by this program in their various countries. During the past 11 years 2,793 PAC personnel participants have been trained in the U.S. and third countries among a total of 12,468 population/family planning participants trained. The PAC personnel were 22.4% of all participants, compared to 29.8% or 3,712 physicians trained during the same period. These people will provide the in-country cadres of trainers which this program can draw on. It is, therefore, feasible to carry out this program.

ADMINISTRATIVE FEASIBILITY

This project does not propose to do new work. Rather it combines and applies technologies, methodologies, mechanisms and lessons learned from previous PAC training projects into a comprehensive training model or framework that will be able to respond to a wider variety of training needs within a geographical or regional area. This project will build upon existing expertise by expanding the abilities of one intermediary to directly provide training services and to provide training services thru subcontracting arrangements. The TSA will be able to intervene at the level of assistance required in each situation. For example the TSA could provide the entire training program (implementing a training program), provide consultation in assisting local trainers or institutions in setting up their own training program, or funding support or monetary assistance to established in-country or third-country programs. The PIO/T will delineate the specific scope of work for each TSA in the specific geographical area. The mode of operation required by this PP while more comprehensive than previous projects is nonetheless feasible in that all previous grantees/contractors have been successfully providing training components of the TSA model and one intermediary, that has been working in Latin America and the Caribbean, providing assistance using the TSA model. As can be seen in Chart X, 76% of total FY 79 training costs or \$1,645,762 was spent in Latin America and the Caribbean utilizing this comprehensive training approach.

DS/POP/TT
 FY 78 FUNDING FOR FAMILY PLANNING TRAINING OF PARAMEDICAL, AUXILIARY
 AND COMMUNITY PERSONNEL, BY COUNTRY

Total FY 78 funding obligated for Project 932-0644 is \$4.225. Please note that grant or contract core costs covering leadership, management and overhead are not attributed to the following country-specific costs. Also the following countries and amounts allocated to each could change as a result of such things as U.S. and/or host country policy changes, DSB and bureau priorities, etc. However, all country specific programming changes are made in collaboration and general agreement with the Regional Bureaus.

LAC

<u>COUNTRY</u>	<u>FUNDING</u>
Argentina	\$ 5,000
Belize	14,000
Bolivia	3,000
Brazil	400,000
Caribbean Regional	50,000
Chile	80,000
Colombia	84,762
Costa Rica	37,500
Dominican Republic	37,500
Ecuador	15,000
El Salvador	50,000
Guatemala	20,000
Haiti	30,000
Jamaica	20,000
Mexico	600,000
Nicaragua	64,000
Panama	30,000
Paraguay	50,000
Peru	50,000
Venezuela	5,000
Total	\$1,645,762

ASIA/NENA

Bangladesh	10,000
Egypt	85,510
India	5,000
Indonesia	26,400
Philippines	22,000
Sudan	10,161
Sri Lanka	16,000
Thailand	172,000
Turkey	4,000
Asia Regional	36,000
Total	\$387,071

AFRICA

Cameroon	31,540
Chad	21,000
Ghana	8,620
Kenya	19,151
Nigeria	12,102
Lesotho	4,000
Sierra Leone	4,000
Swaziland	4,000
Zaire	4,000
Francophone Regional	<u>29,175</u>
	\$137,588

TOTAL COUNTRY SPECIFIC COSTS**(% of total)**

LAC	\$1,645,762	{76%}
ASIA/NENA	387,071	(18%}
AFRICA	<u>137,588</u>	(6%}
	\$2,170,421	

This project is designed as a follow-on to PAC training activities of six previous contracts/grants. Activities of these existing centrally funded contracts/grants which will be incorporated into this project are:

- 1) Downstate Medical Center - prepares LDC nurses/midwives to deliver and teach clinical contraceptive and reproductive health techniques, and through U.S. training programs assists institutions and governments to establish training programs in LDCs.
- 2) African Health Training Institutions Project (UNC) - assists African medical schools and/or related paramedical training institutions in the design and implementation of family planning curricula.
- 3) Development Associates, Inc. - provides training for health professionals and non-physicians from Latin America in health and family planning through programs in U.S. and in Latin America.
- 4) University of Hawaii - provides both long-term higher degree training and short-term health/family planning training to health professionals and para professionals both in Hawaii and Asia.
- 5) International Confederation of Midwives - stimulates and promotes midwives throughout the world to provide family planning information and services to people in LDCs.
- 6) Planned Parenthood Association of Chicago - provides specialized tailor-made short term programs for family planning personnel in the U.S.

In addition to the projects listed above, the Africa Bureau funds a project carried out by the University of California at Santa Cruz in Gambia, Benin and Lesotho for the demonstration and training for Maternal Child Health/Family Planning Services. Title X services funded under this project might be incorporated into the umbrella project, also. To get a clearer picture of how the various activities of preceding intermediaries fit into the TSA model Chart XI, describes the Management/Supervision Capabilities as well as professional expertise of each previous training project. It can be seen in comparison to the TSA Model that each project has provided at least a part of the necessary training functions required to serve as a TSA.

The institutions which are already supplying the services listed above, along with a number of additional ones which have experience and capability in international training, will be the pool from which the necessary competitive proposals will be sought to become the Training Service Agencies to carry out this program.

Similarly there are many LDC training institutions already identified and utilized and it is certain that it will be possible to make arrangements to collaborate with enough to fully utilize the resources to be made available. The past performance of these LDC institutions will be sufficiently successful to justify this effort. The TSA's will build into their operational procedures evaluation techniques for selection and performance rating such that the dangers of selecting an incompetent LDC institution will be minimal, the subagreements they will make will provide for phasing out support should the evaluation show that a given institution is not performing adequately.

The ultimate monitoring responsibility for this program will rest with the Training and Institutions Division of DS/POP. This central monitor will work in close collaboration with the Regional Bureaus and, with and through them, with the Country Missions where there are Bilateral programs. In countries where there are no Bilateral Programs the central monitor and the TSA will work with the appropriate LDC institutions. Present and past experience confirms the feasibility of this approach.

e. Environmental Concerns

This project will have no direct impact on the environment. It will indirectly have a favorable impact in so far as it results in a gradual slowing of population growth and thereby slows when the rate at which population growth increases the pressure on all of the life support systems.

* Models of Previous TI Training Projects in Relation to the TSA Model

Development Associates, Inc.

1. Provides the management and supervision mechanisms for all three levels of training assistance to all three categories of PAC personnel.
2. Provides professional training in management/supervision (1 of 4 activities) to Paramedics (1 of three categories).

Comment:

DAI has minimum qualifications in terms of present scope of work to qualify for a TSA. Works primarily in Latin America.

Downstate Medical Center

1. Provides management and supervision mechanism for implementation level assistance (1 of 3 levels) to Paramedics (1 of 3 categories).
2. Provides professional training in technical skills (1 of 4 activities) to Paramedics (1 of 3).

Comment:

Downstate offers superb clinical skills training to paramedics in the U.S. however narrow in training focus. Works worldwide.

African Health Training and Institutions Project (AHTIP)

1. Provides management and supervision mechanisms for implementation and technical assistance/consultation (2 of 3 levels) to Paramedics (1 of 3).
2. Provides professional training in pre-service and management/supervision (2 of 4) to Paramedics (1 of 3).

Comment:

AHTIP has developed a cadre of trained nurse/midwifery faculty members in the area of pre-service education and has developed African authored training materials currently being printed under contract with the Africa Bureau. Works in six African countries.

University of Hawaii

1. Provides management and supervision mechanism for implementation and some technical skills/consultation (2 of 3) to Paramedicals (1 of 3).
2. Provides professional training in pre-service and management/supervision (2 of 4) to Paramedicals (1 of 3).

Comment:

University of Hawaii has primarily offered fellowships to Asian Student (1 year or less) in public health at the University. Recently they have been moving toward providing in-country workshops.

International Confederation of Midwives (ICM)

1. Provides management and supervision for technical assistance/consultation (1 of 3) to Paramedical, Auxiliary and Community Workers (all three categories - with emphasis on traditional health workers).
2. Provides professional training in technical skills, management/supervision, and training trainers to Paramedical, Auxiliary and Community Personnel (all three categories - with emphasis on traditional health workers).

Comment:

ICM is unique in that it has worked thru its professional affiliation in reaching midwifery professional groups in changing standards of practice to include family planning and to incorporate traditional midwives into the health care delivery system by upgrading skills and instituting referral mechanisms.

* See Chart IV - Components of the Training Service Agency (TSA) Model

In Summary:

- | | |
|------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Levels of Assistance = | <ol style="list-style-type: none"> 1. Implementation 2. TA/Consultation 3. Monetary |
| Training Activities = | <ol style="list-style-type: none"> 1. Technical Skills 2. Pre-Service Preparation 3. Management/Supervision 4. Training Trainers |

FINANCIAL PLAN

This is a grant program designed to foster and support training assistance for non-physician health, auxiliary and community personnel in a wide array of LDC's. It gives special emphasis to the requirements for family planning knowledge and skills throughout five classes of health/family planning delivery systems. Whenever possible it seeks to meet the requirements of "integrated" services. It includes a concern for reaching out well beyond traditional clinic systems to community based efforts to make family planning information and services easily available to whole populations including the most remote of the rural poor.

These parameters of need and purpose require new and creative attacks on the problems of training and using special types of personnel including policy change, training, on-the-job and refresher training and creative follow-up and supervision throughout each operational program. This is a tall order that requires rather large scale and extensive effort sustained over enough time (which will vary from region to region and country to country) to achieve significant impact on an important need. The financial plan, therefore, is designed to be somewhat commensurate with the size and complexity of the problems and needs it addresses.

It is estimated that, over the next five years a total of \$33,310,000 of AID Population Planning grant money will be required to fund this program. In order to achieve the level of coordination, effective management, flexibility and creative monitoring this program requires the principle source of funding is to be interregional money. There is also built into the plan a flexible capacity for linking funds from other sectorial, regional or country accounts to provide maximum capacity to integrate the training of paramedical, auxiliary and community personnel across whatever span of subject matter or operational organization that specific situations in regions or countries may require.

The funding level of this program calls for an increase of resources for this training purpose as compared to the level at which the six projects that will be phased into it have been funded. In 1976 a total of \$4,225,000 has been obligated for these predecessor projects, and in FY 77 a total of \$4,785,000 has been obligated. It is estimated that over the five years of the new program an average of \$7,062,000 will be committed each year. Over the life of the project the new funding will amount to an increase of about \$13,310,000 over the former rate of investment.

At this juncture it is not feasible to quantify the amounts of AID funding from other than Population Planning sources that may be linked into this more widely integrated training program. Similarly, undoubtedly there will be considerable host country or host institution resources both in cash and in kind provided for this training. It is not now possible to estimate the magnitude of such resources.

The costs and financial plan for this program are set out in Chart XII, "Summary Cost Estimate and Financial Plan". The estimated cost breakdown shows that the leadership and management costs of this program which will be the costs involved in the operation of the several Training Service Agencies (TSAs) which the program will use, will be about \$12,358,000 over the five year life of the project. This is about 35% of the \$35,310,000 which is the total estimated AID Population Planning input. From the earlier descriptions of the purposes and methods of operation of this project it is evident that each TSA will have to be both creative and efficient to obtain the results that are needed. It is not unreasonable that the leadership, management and the international technical assistance in this program should require slightly more than one third of the total costs. Salaries for the TSA's will be 15%, overhead 8% and consultants 4% of total costs. The training costs comprise 65% of all costs broken into costs for travel and maintenance of participants 12.6% (Host countries will bear much of this class of costs for the large amounts of in-country training which will be delivered); subcontracts or grants for training services 22.3%; grants and other subventions to LDC training institutions for temporary start-up costs 15%; curriculum and teaching materials development 1.8%; reproduction and use of teaching materials 4.7%; and seminars, workshops and conferences 6.9%.

The interrelations between inputs and outputs is shown in Chart XIII "Costing of Project Outputs/Inputs". It should be noted that these costs can be broken in two ways: by how much goes to each of the estimated LDC regional and country training centers and/or programs which are shown as output 1. In fact it is not now possible to realistically break the budget on this pattern. Therefore the output 1 column shows the sum of all the other 7 outputs for each of the inputs in brackets as no add figures. This column, therefore shows the estimated amount of money which will be spent on each of the inputs over the life of the project.

The estimated amount to be spent on each output 2 to 8 are shown in the respective columns. Note that outputs 2, 3 and 5 all have two

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

SOURCE	AID		HOST COUNTRY		TOTAL	
	Pop.	Planning Other Accts.	FX	IC	FX	IC
USE						
TSA's Salaries	5,685	*	-	-	5,685	-
TSA's Overhead	2,842	*	-	-	2,842	-
TSA's Travel, Transpt., Comm., Office Costs	2,348	*	-	-	2,348	-
TSA's Consultants	1,483	*	-	-	1,483	-
Sub Total	12,358	*	-	-	12,358	-
Training Costs						
Participants	4,285	*	-	**	4,285	**
Contracts for Services	7,668	*** *	-	**	7,668	**
Support to LDC Institutions	5,187	*	-	-	5,187	-
Materials Development	1,353	*	-	**	1,353	**
Materials Production & Utilization	1,579	*	-	**	1,579	**
Seminars, Workshops, Conferences	2,480	*	-	**	2,480	**
Sub Total	22,952	*	-	**	22,952	**
TOTAL	35,310	*	-	**	35,310	**

* Regional Bureau as Health Accounts, amounts to be determined in individual cases.
 **Host Country government and/or institution will provide considerable resources in kind but also in cash, however it is not now possible to estimate the value of these resources.

*** Funds from this line item will be reserved to finance 1982 and 1984 external evaluation costs totaling approximately \$400,000.

Code:

IC = In-Kind contribution

FX = Foreign Exchange

subcolumns, one for the costs of the respective types of LDC personnel that will be trained directly in centers or programs assisted by this program and one for the costs that will go to the training of secondary and tertiary participants who will be trained by those that are directly trained. It is estimated that this program would expend funds for this secondary training only by the efforts of the TSA's to stimulate, enumerate and evaluate the indirectly supported training. If in some cases these secondary training efforts require other help from this program such assistance would flow from the training cost items listed in the directly trained sub-columns.

Presented as a percentage of total costs outputs 2 to 8 would share as follows - non-physician health professionals (paramedicals) about 25%; auxiliaries 24%, community workers (CBD) 17%; administrators, managers, officials and physicians 5.5% policy and standards setting efforts 10%; training of trainers and training systems assistance 8%; and curriculum development assistance 10%.

Chart XIV "Estimates of How Resources are to be Applied by the Using Agencies". The relative need for training and the degree of catching up in health and family planning that a region has to do are among the more important factors considered in estimating the average yearly and life of project investments this program will make. Asia has the lowest annual and total important rates of the three regions and Africa/NENA the highest. An overwhelming 87% of the money is planned to be used by the RTSAs and the remainder to STSAs.

COSTING OF PROJECT OUTPUTS/INPUTS (IN \$000 OR EQUIVALENT)

PROJECT INPUTS	1. Training Centers Assisted (77)		2. Non-physician Health Professionals		3. Auxiliaries Trained		4. Community Workers Trained		5. Admin. Mgmt. Officials, Physician Trained in use of Pers. & Auxil.		6. Policy & Standards Meetings Held	7. TOT & Tr Systems Assistance Provided	8. Curriculum Development Assistance Provided
	Directly (4,500)*	Indirectly (35,000)*	Directly (19,000)*	Indirectly (74,500)*	Directly (20,000)*	Indirectly (33,500)*	Directly (1,300)*	Indirectly (1,700)*	(1,520)*	(750)*	(1,410)*		
AID TITLE X APPROPRIATED**													
TSA's Salaries	(5747)	1121	294	734	424	1049	121	236	29	879	584	276	
TSA's Overhead	(2875)	560	150	375	216	525	62	118	15	430	286	138	
TSA's Travel, Transp. Comm. & Office	(2261)	438	120	294	173	410	49	92	10	337	224	114	
TSA's Consultants	(1452)	317	36	228	52	297	15	66	-	225	149	72	
TSA Cost Sub Total	(12342)	2436	600	1631	865	2281	247	512	54	1871	1243	600	
Training Costs													
Participants	(4398)	1621	-	921	-	1117	-	464	-	-	475	-	
Contracts for Training Services	(7870)	2388	-	3375	-	856	-	389	-	182	680	-	
Support to LDC Institutions	(5119)	1535	-	1841	-	1303	-	213	-	-	427	-	
Materials Development	(1290)	-	-	-	-	-	-	-	-	-	-	1290	
Materials Production & Utilization	(1641)	-	-	-	-	-	-	-	-	-	-	1641	
Seminars, Workshops, Conferences	(2452)	342	-	-	-	446	-	188	-	1477	-	-	
Training Cost Sub Total	(22979)	5685	-	6137	-	3722	-	1254	-	1659	1582	2931	
TOTAL	(35310)	8121	600	2268	865	6003	247	1766	54	3530	2825	3531	
OTHER AID***													
BOST COUNTRY	****	****	****	****	****	****	****	****	****	****	****	****	****
TOTAL	(35310)	8121	600	2268	865	6003	247	1766	54	3530	2825	3531	

* Estimated number of individuals trained and/or retrained in 5 years. **Population (Title X) Account.

***Regional Bureau or Health accounts, amounts to be determined in individual cases.

****Host governments and/or institutions will provide considerable resources in kind, but also in cash, however it is not now possible to estimate the value of these resources.

ESTIMATES OF HOW RESOURCES ARE TO BE APPLIED BY THE USING AGENCIES
(in thousands)

USING AGENCY	AVERAGE ANNUAL RATE	TOTAL OVER 5 YEARS
1. RTSA		
a. Asia	\$ 1,695	\$ 8,475
b. Africa	2,330	11,652
c. LA & C	2,119	10,593
2. STSA	918	4,590
TOTAL	<hr/> \$ 7,062	<hr/> \$ 35,310

PROJECTION OF EXPENDITURES BY FISCAL YEAR

(US \$000)

PROJECT PAPER

FISCAL YEAR	AID GRANTS			HOST COUNTRY	TOTAL
	Title X	Other	Total		
1979	4,785	*	4,785	**	4,785
1980	5,200	*	5,200	**	5,200
1981	8,441	*	8,441	**	8,441
1982	8,442	*	8,442	**	8,442
1983	8,442	*	8,442	**	8,442
TOTAL	35,310	*	35,310	**	35,310

* Regional Bureau accounts, amounts to be determined in individual cases.

** Host governments and/or institutions will provide considerable resources in kind, but also in cash, however it is not now possible to estimate the value of these resources.

The Projection of Expenditures by Fiscal Years is shown in Chart XV. Fiscal year 1979 money which will be expended, for the most part in FY 80 is estimated at \$5,200,000 because much of that year will be used in program start-up. By the following year the program will be up to full speed and will, therefore, be able to use resources at the \$8,500,000 level. It will remain at that level through the remaining years of the operation.

5. IMPLEMENTATION PLAN

Schedule

The proposed implementation schedule for this program covering five grants/contracts - LAC/RTSA; Asia/RTSA; AFR/RTSA; NENA/RTSA; STSA - is estimated to run as follows:

	<u>1978</u>
a. Draft Project Paper Completed	November 1
b. DS/POP Review	November 21
	<u>1979</u>
c. Circulated to DS Offices & Regions	January 10
d. Agency Wide Review	January 23
e. Action Memo for Administrator and Project Authorization and Request for Allotment of Funds	February 9
f. PIO/Ts Approved	February 20
g. RFP's Issued	March 16
h. Proposals Opened	April 30
i. Technical Evaluation Completed	May 18
j. Best and Final Offer	May 31
k. Contracts or Grants Signed	July 1
l. Operations Beginning Date	July 1
m. Start-up Organization and Pick-up Certain Ongoing Activities	July - Sept. '79

- n. Field Planning Work on New Activities Oct - Dec '79
- o. Baseline Data for Each Country Plan Collected to Provide Benchmark for Evaluation June - Dec '79
- p. In-country, Regional and U.S. Training to Begin New Programs Jan - March '80
- q. First In-house Evaluation made by Monitors in Cooperation with TSA's to check Progress Toward Quantitative and Qualitative Goals April - June '80
- r. Additional training assistance sub-projects reaching 15 in-country, 3 regional and 3 U.S. Centers by April - June '80
- s. Training Assistance being provided to 25 in-country, 5 regional and 4 U.S. centers by April - June '80
- t. Second in-house evaluation completed during April - June '81
- u. Training assistance being provided to 35 in-country, 7 regional and 4 U.S. centers by (See output Chart IX, for projected number of trainees)
- v. Full scale external evaluation carried out between January and June '82. This is a key evaluation that will assess continuing need, TSA performance, program effectiveness and impact and will make recommendations on whether more, all, or what parts of program will be continued beyond June 1984. January - June '82
- w. Training assistance being provided 50 in-country, 8 regional and 4 U.S. centers (U.S. Centers may be phasing out) by April - June '83
- x. In-house evaluation will be done April - June '83

y. Training assistance being provided 65 in-country, 8 regional and 1 or more U.S. centers by

Oct - Dec '83

z. Depending on continuation decision made after 1982 evaluation final evaluation or 2nd full scale external evaluation will be done.

January - June '84

IMPLEMENTATION RESPONSIBILITY

As fully explained in the detailed description of this program in section 2, the strategy of this program is to work through a series of Training Service Agencies to implement the required actions. This is the only feasible way to tap the experience and expertise of training institutions capable of managing international training on the one hand and working within the limitations now in effect on direct hire AID personnel at central, regional and country levels, on the others.

One alternative to using such Agencies, it might be argued, would be to put the assistance to paramedical and auxiliary training into the hands of the AID country missions. There are several major difficulties which make this an unworkable option.

- a. There are no direct hire slots to provide specialized training advisors to missions.
- b. The training advisor work load in most countries is not sufficient to adequately occupy such full time training advisors.
- c. Many countries which need FP training have no AID Missions.
- d. There is much existing ability to train in many countries that only requires short time, in and out, advisors or technical help to catalyze the needed improvement.
- e. A limited number of persons working in a TSA can effectively and economically meet the needs for training service assistance in the countries of a region.
- f. The generation of a series of small, country program funded, contracts to meet the training service needs of countries is so cumbersome and time consuming that most AID Missions will not rate it high enough to tackle so, without central contracting and technical help and guidance, the training needs are neglected.

In using centrally contracted Agencies to do this work it will be necessary from the beginning to fully involve both country and regional planning and monitoring devices through all stages of implementation to insure that planning and execution is optimally responsive to country and regional needs and conditions.

MONITORING RESPONSIBILITY

As indicated above, planning and monitoring inputs from country, regional and central levels will be required for this program. The monitoring function will be carried out by a monitoring team. The responsibility for coordinating and orchestrating the monitoring functions will be lead by the TI Division of the Office of Population which plans to devote two full time professional specialists to this task. With this investment of personnel it will be possible to provide the training services required to meet country needs and fulfill Congressional expectations for expanded and more effective use of paramedical and auxiliary personnel in family planning and health programs. At the same time Mission and Regional Bureau Officers will be involved in some degree of monitoring to be determined desirable by each regional bureau. The specific division of monitoring responsibility carried by each of the interested organizational entities can be determined in each specific case. The drafting and clearing of the PIO/Ts that define the work scopes of the TSA's will be a principal mechanism in defining the make-up of the monitoring team and the mix of monitoring responsibilities. Specific country plans and subprojects developed by the TSA's in conjunction with the interested monitoring parties and approved by the monitoring team revised and updated on an annual basis will be additional mechanisms by which monitoring on an integrated basis will be carried out. These mechanisms will permit adjustments of the monitoring mix to conform to changing conditions and needs.

Selection of TSA's

This has been discussed in a previous section of the PP.

6. EVALUATION PLAN FOR THE PROGRAM

Evaluation will be a significant element in this project. Each TSA will be expected to build a strong evaluation component into its staffing and operations. The nature of the project, involving close interaction between the TSA's and a variety of country programs and separate public and private LDC institutions, will require a variety of approaches to evaluation. Since one of the important services each TSA will supply will be needs assessment and cooperative program planning, there will be opportunity to design evaluation into each subproject or program. The TSA's will be expected to lead into evaluation in such a way that the assistance receiving entities will not resent the understood requirement for evaluation. Indeed it should be planned and carried out in such a way that the assistance receivers understand the importance of the evaluation process as planning and management tools which they will wish to acquire and use long after the period of external assistance has ended. Some form of project agreement will be developed between the TSA's and those they assist that will include evaluation plan details.

Baseline Data: There is a certain amount of training baseline data now available. The largest piece of it consists of the data on the international training which AID, its contractor grantees, the UN System and other donors have trained outside of their home countries between 1966 and 1977. This data has already been referred to. In Chart XVI the breakdown of the 2,793 PAC personnel in the Health Care Category is shown by region and profession. In Chart XVII the number and percentage of all trainees from 63 countries are shown for Physicians and PAC personnel arranged alphabetically by regions. Study of this data and the printouts of the detailed information on each trainee, which shows considerable detail about them, will supply the take-off point for the TSA's to add to what other baseline data about health and family planning training needs, institutions, resources and the like which they already have to build a more adequate data base for planning programs. As an integral part of the work plan that will be developed for each country where they work the TSA's will provide for the gathering of the basic data at the baseline and as the program progresses. It is suggested that useful types of rates to be developed and used will include those that measure the types and numbers of trained paramedical, auxiliary and community personnel per 10,000 of families with women of reproductive age as one means of measuring the availability of family planning and related health services.

In the discussion of outputs it has already been noted that the TSA's will be expected to devise and operate ongoing data collection and analysis systems by which they can follow the numbers trained and the quality of training given the various classes of personnel that are trained in projects which the TSA's directly assist as well as such data on those who are indirectly assisted as a result of the secondary and tertiary pass-on training that the primary project graduates provide. These data will be monitored as appropriate by the agreed upon AID Mission, Regional Bureau and Office of Population monitors.

As already laid out in the implementation plan there will be an in-house evaluation of this program conducted by the AID monitors and the relevant TSA evaluation staff during the final quarter of the first and second operations years now projected to be April - June 1980 and 1981. The purpose of these evaluations will be to assess progress toward the stated goals of the program, analyze the strength of the activity, seek weaknesses and devise modifications and improvements that can be identified by studying the actual operating experience. Such modifications or improvements would then be incorporated into the work plan for the following operational year. It should be emphasized that qualitative judgements will be an important element in these annual in-house evaluations.

At the halfway point of the five year operating period, January - June 1982, the evaluation plan calls for a full scale External Evaluation of the program. The purpose of this evaluation is to provide the specific information that AID Administrators will require to assess needs, effectiveness and cost relationships which will be the basis on which decisions to phase out all or selected parts over the next two years, or continue the whole program or selected parts of it for additional periods of time beyond 1984, including the length of those periods.

In 1983 there would be another progress monitoring in-house evaluation that would assess progress in implementing the decisions that resulted from the evaluation made in 1982.

In 1984 there should be another external evaluation which would be either a "Final Evaluation" for all or part of the activities or be a guide to continued operations depending on the 1982 decisions. Adequate resources for these actions can be provided within the projected budgets. In the development of the PIO/Ts there will be a line item included in the budget to cover external or indepth evaluation costs amounting to an estimated cost of \$50,000 for each evaluation, of which during the life of the project there will be two for each TSA, or a total of \$400,000 for the four TSA's. More detailed plans for each of the TSA's adjusted to their particular situations will be spelled out in the PIO/Ts that will control the scope of work each will undertake.

Frequency of Professions by Region of 12,468 Persons Trained Internationally between 1966 and 1977

Profession	Africa			Asia, E & SE			Asia, South			Caribbean			Latin America			Near East			Total		
	No	% PAC	% All	No	% PAC	% All	No	% PAC	% All	No	% PAC	% All	No	% PAC	% All	No	% PAC	% All	No	% PAC	% All
Physicians	313	—	19.5	886	—	29.0	586	—	29.0	148	—	23.8	1552	—	36.8	233	—	33.4	3712	—	29.8
Nurses	177	21.9	11.0	180	34.0	5.9	67	23.8	3.4	89	43.8	14.3	458	42.4	10.1	11	29.0	1.6	982	35.2	7.9
Nurse-Midwives	326	51.8	20.9	31	9.6	1.7	38	20.6	3.0	62	20.5	10.0	137	12.7	3.0	8	21.1	1.2	652	23.3	5.2
Midwives	66	18.0	4.1	93	17.6	3.2	10	3.6	0.5	4	2.0	0.6	139	12.9	3.1	2	5.3	0.3	314	11.2	2.5
Public Health Workers	20	2.8	1.3	63	16.8	2.8	69	24.3	3.3	13	6.4	2.1	46	4.3	1.8	3	7.9	0.4	236	8.5	1.9
Health Educators	66	7.8	2.9	64	12.1	2.1	68	24.1	3.3	4	2.0	0.6	43	4.0	1.8	4	10.5	0.6	229	8.2	1.8
Social Workers	14	2.1	0.9	36	18.6	1.8	18	3.6	0.5	28	9.9	3.2	222	20.5	4.9	18	26.2	1.4	332	11.9	2.7
Nurse Assistants	—	—	—	1	0.1	0.1	—	—	—	11	5.4	1.8	36	3.3	0.8	—	—	—	48	1.7	0.4
Total Non-Physicians	639	100.0	41.1	520	100.0	17.5	282	100.0	14.4	203	100.0	12.6	1081	100.0	23.9	38	100.0	5.5	2793	100	22.4
Total All Professions	1653	—	—	2031	—	—	1964	—	—	623	—	—	4527	—	—	698	—	—	12468	—	—

Note: Regional totals for PAC personnel are larger than in Chart 12 because Health Educators and Social Workers are included here but are not in Chart 12.

**Trainees Distribution According to Professional
Background and Nationality
Health Care Categories**

Region & Country	Physicians		PAC Personnel	
	No	% Of All Trainees	No	% Of All Trainees
AFRICA				
1. Algeria	7	20.0	1	2.9
2. Botswana	2	5.3	31	81.6
3. Ethiopia	6	13.0	26	36.5
4. Ghana	21	12.7	41	24.6
5. Kenya	46	42.6	30	27.8
6. Lesotho	2	6.1	22	60.6
7. Liberia	3	7.2	43	62.2
8. Mauritius	3	19.2	4	13.3
9. Morocco	9	19.0	0	0.0
10. Nigeria	80	36.4	38	26.4
11. Sierra Leone	7	9.0	33	42.4
12. Sudan	40	43.0	17	18.3
13. Swaziland	0	0.0	20	24.0
14. Tanzania	14	11.1	19	42.2
15. Tunisia	18	18.1	7	10.9
16. Zaire	10	12.1	13	43.4
Total	113	23.8	307	36.9
ASIA, EAST & SOUTHEAST				
1. Indonesia	131	13.3	30	4.9
2. Korea	82	14.4	48	16.4
3. Laos	33	14.3	80	38.8
4. Malaysia	28	20.1	12	8.6
5. Philippines	260	40.4	77	12.0
6. Taiwan	62	33.0	74	13.7
7. Thailand	219	38.4	103	18.3
8. Vietnam	19	12.0	48	49.6
Total	886	13.3	629	16.1
ASIA, SOUTH				
1. Afghanistan	27	23.0	37	30.1
2. Bangladesh	36	23.0	20	9.0
3. India	117	30.1	33	3.4
4. Nepal	36	22.4	30	18.5
5. Pakistan	97	33.4	47	13.7
6. Sri Lanka	16	18.0	19	12.0
Total	380	16.1	260	11.3
CARIBBEAN IRL.				
1. Antigua	1	11.1	6	66.4
2. Barbados	0	0.0	3	30.0
3. Cuba	0	42.1	0	0.0
4. Dominican Republic	12	28.3	18	31.5
5. Haiti	17	49.7	30	37.0
6. Jamaica	30	24.6	36	29.3
7. St. Lucia	1	12.8	3	42.5
8. Trinidad & Tobago	0	19.2	12	31.4
Total	128	18.3	188	24.8
EUROPE				
NEAR EAST				
1. Egypt	97	30.0	7	3.6
2. Iran	83	33.3	6	6.9
3. Iraq	6	30.0	1	6.3
4. Jordan	9	43.0	1	9.0
5. Lebanon	10	47.6	2	9.6
6. Saudi Arabia	3	13.3	0	0.0
7. Syria	8	42.1	0	0.0
8. Turkey	17	18.4	0	0.0
Total	133	44.7	18	1.3
LATIN AMERICA				
1. Argentina	68	30.1	17	16.3
2. Bolivia	77	33.3	83	36.3
3. Brazil	41	44.3	13	9.3
4. Chile	109	39.3	37	18.6
5. Colombia	134	16.3	79	12.3
6. Costa Rica	66	28.9	41	23.8
7. Ecuador	88	21.3	24	19.4
8. El Salvador	66	33.7	27	19.4
9. Guatemala	42	34.0	37	24.2
10. Honduras	33	33.3	33	33.4
11. Mexico	366	69.7	30	9.6
12. Nicaragua	49	33.2	40	26.4
13. Panama	60	30.3	33	40.3
14. Paraguay	41	16.4	100	40.8
15. Peru	78	32.0	26	29.3
16. Venezuela	39	11.4	16	8.6
Total	1,332	29.7	643	12.6
Grand Total	3,713	29.8	1,190	18.3

EVALUATIVE ELEMENTS AND LINKAGES

The key evaluative elements that will be important for the evaluation process will be the following targets for Outputs, Project Purpose, Sector Goal and Output Targets, by operational year:

<u>Outputs</u>	<u>Op. Year</u>				
	(Year 1)	(Year 2)	(Year 3)	(Year 4)	(Year 5)
(Direct Assistance Only)					
Training Project Assisted	21	34	46	62	77
Nurses/NMs, Midwives Trained	630	1,450	2,383	3,400	4,500
Auxiliaries Trained	4,000	8,500	14,500	21,500	28,500
Community Workers Trained	3,800	8,700	13,200	17,800	22,500
Managers, Physicians Trained	125	250	550	825	1,300
Utilization Policy and Standard Meetings Held	(15)*390**	(32)*720**	(46)*1,020**	(60)*1,350**	(69)*1,520**
TOT & Trn'g Systems Assisted	(5)*150**	(10)*300**	(15)*450**	(20)*600**	(25)*750**
Curriculum Development Assistance					
Consultations	20	35	50	65	80
Workshops and Conferences	(5)*250**	(10)*500**	(15)*450	(20)*600**	(25)*750**
Materials Developed (Titles)	25	50	60	70	80
Materials Distributed (Pieces)	50,000	150,000	225,000	350,000	580,000

(*) = Number of meetings
 ** = Number of participants

These outputs appropriately combined and applied to specific needs situations as operational subprojects will result in the achievement of the following Project Purpose Targets.

PROJECT PURPOSE TARGETS

This program seeks to reach the following four project purpose targets.

a. Stimulate LDC FP/Health systems to adopt policies that permit paramedical, auxiliary and community (PAC) personnel to have expanded roles in service delivery. This will be achieved primarily by the use of outputs 5 and 6.

b. Sharply increase the capacity of PAC personnel to deliver appropriate high quality service through each of the five delivery systems which can supply family planning services. The achievement of this project purpose target will involve varying mixes of all eight of the outputs. The variation in the mix will be determined by the conditions and needs of each specific situation.

One purpose of the evaluation process will be to determine how appropriate and effective the various mixes turn out to be, and provide recommendations on how to improve them.

c. Permanently improve the quality strength and size of PAC training systems so they can meet country needs for all types of PAC personnel. Outputs 5,6,7 and 8 will be principle means of reaching this target.

d. Train large numbers of PAC personnel. This target will involve outputs 1 to 8. Because of the nature of the effects of rapid population growth on health and on development the rapid expansion of the size of the PAC personnel force available to complete the expansion of FP means availability to put them in easy reach of the entire population no matter how remote, is one of the most important project purpose targets. Developing yardsticks to measure the optimum numbers of PAC personnel to achieve this availability and applying them to determine cost effectiveness break points can be an important evaluation outcome.

SECTOR GOAL TARGETS

The sector goal targets which this program contributes to are:

a. To assist many LDC's to have family planning and health programs which provide protection from unwanted pregnancy for all their families by making the needed information and means available.

b. To aim for 65 to 70 percent of all fertile aged couples to practice family planning using effective means.

The achievement of these targets depends on many factors other than adequate and effective PAC personnel. However, such personnel are one of the essential components in achieving these targets. Without adequate quantities of good quality PAC personnel it will be impossible to provide the extent and quality of services required to reach these sector goals.

The evaluation process can serve to refine the numerical measures that define the cost effective limits of PAC personnel training and use.

**PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK**

Project Title & Number: FP Training for Paramedics/Auxiliaries 932-0644

Life of Project:
From FY 79 to FY 83
Total U S Funding 35,310
Date Prepared: January 1979

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS																																																																														
<p>Program or Sector Goal: The broader objective to which this project contributes. LDC family planning and health programs provide the information and means needed to protect all families from unwanted pregnancy. From 65 to 70% of fertile couples are practicing family planning using effective means.</p>	<p>Measures of Goal Achievement: Proportion of population that has the information and means for practicing family planning easily available to them. Percentage of reproductive aged couples that are practicing family planning by effective methods.</p>	<p>Country specific data on number and location of points where effective means are available. Service statistics on users. World Fertility Survey and other survey and census data.</p>	<p>Assumptions for achieving goal targets: 1. Development will provide economic base for continued growth of primary and secondary health care systems in most LDC's. 2. Favorable trend among LDC's to have and implement FP policies and/or programs will continue. 3. Traditional ignorance, cultural, religious barriers to practice of family planning will continue to weaken and disappear.</p>																																																																														
<p>Project Purpose: Strengthen and expand LDC FP and health in-service and pre-service training systems for Paramedical, Auxiliary and Community (PAC) personnel, and change the conditions that inhibit extensive use of PAC personnel.</p>	<p>Conditions that will indicate purpose has been achieved. End of project status: 1. PAC personnel training systems better organized, staffed, more efficient. 2. Large numbers trained and used providing expanded FP services. 3. Quality and efficiency of PAC provided services improved. 4. Up to 40 LDC's will have expanded number of PAC personnel delivering more varieties of services than is now the case.</p>	<p>1. TSA maintain quantitative and qualitative data on training activity. 2. Output data (see below). 3. TSA and external evaluation data and studies. 4. Baseline and longitudinal data on numbers of PAC personnel employed and on varieties of services supplied.</p>	<p>Assumptions for achieving purpose: 1. Most LDC's have in-service, and pre-service training systems and/or institutions that can be strengthened and expanded. 2. Policies and practices that inhibit wide use of PAC personnel will be changed.</p>																																																																														
<p>Outputs:</p> <table border="1"> <tr> <td></td> <td colspan="2">Magnitude of Outputs</td> <td colspan="3">Cumulative</td> </tr> <tr> <td></td> <td>Yr. 1</td> <td>2</td> <td>3</td> <td>4</td> <td>5</td> </tr> <tr> <td>1. Training projects assisted</td> <td>21</td> <td>34</td> <td>46</td> <td>62</td> <td>77</td> </tr> <tr> <td>2. Nurses, N/No, Midwives trained</td> <td>630</td> <td>1450</td> <td>2383</td> <td>3440</td> <td>4550</td> </tr> <tr> <td>3. Auxiliaries trained</td> <td>4000</td> <td>8500</td> <td>14500</td> <td>21500</td> <td>28500</td> </tr> <tr> <td>4. Community workers trained</td> <td>3800</td> <td>8700</td> <td>13200</td> <td>17800</td> <td>22500</td> </tr> <tr> <td>5. Managers, physicians trained</td> <td>125</td> <td>250</td> <td>550</td> <td>825</td> <td>1300</td> </tr> <tr> <td>6. Utilization, policy, standards mgt.</td> <td>15</td> <td>32</td> <td>46</td> <td>66</td> <td>69</td> </tr> <tr> <td>7. TST & ring systems assistance</td> <td>5</td> <td>10</td> <td>15</td> <td>20</td> <td>25</td> </tr> <tr> <td>8. Curriculum development assistance</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td> Consultations</td> <td>20</td> <td>35</td> <td>50</td> <td>65</td> <td>80</td> </tr> <tr> <td> Workshops and conferences</td> <td>5</td> <td>10</td> <td>15</td> <td>20</td> <td>25</td> </tr> <tr> <td>9. Materials developed (titles)</td> <td>25</td> <td>50</td> <td>60</td> <td>70</td> <td>85</td> </tr> </table>		Magnitude of Outputs		Cumulative				Yr. 1	2	3	4	5	1. Training projects assisted	21	34	46	62	77	2. Nurses, N/No, Midwives trained	630	1450	2383	3440	4550	3. Auxiliaries trained	4000	8500	14500	21500	28500	4. Community workers trained	3800	8700	13200	17800	22500	5. Managers, physicians trained	125	250	550	825	1300	6. Utilization, policy, standards mgt.	15	32	46	66	69	7. TST & ring systems assistance	5	10	15	20	25	8. Curriculum development assistance						Consultations	20	35	50	65	80	Workshops and conferences	5	10	15	20	25	9. Materials developed (titles)	25	50	60	70	85	<p>Implementation Target (Type and Quantity) 6785 5230 8441 8441 8442</p> <p>At least 3 STSA's and one STSA's will be selected and functioning by June 1979.</p>	<p>Detailed country and TSA data and reports on all activities supported by this project. Monitor field visits, USAID observation and reporting, formal evaluations.</p>	<p>Assumptions for achieving outputs: 1. Effective, mutually helpful working relations can be established between TSA's and LDC programs and institutions. 2. There are sufficient PAC personnel available to permit the projected numbers to be trained.</p>
	Magnitude of Outputs		Cumulative																																																																														
	Yr. 1	2	3	4	5																																																																												
1. Training projects assisted	21	34	46	62	77																																																																												
2. Nurses, N/No, Midwives trained	630	1450	2383	3440	4550																																																																												
3. Auxiliaries trained	4000	8500	14500	21500	28500																																																																												
4. Community workers trained	3800	8700	13200	17800	22500																																																																												
5. Managers, physicians trained	125	250	550	825	1300																																																																												
6. Utilization, policy, standards mgt.	15	32	46	66	69																																																																												
7. TST & ring systems assistance	5	10	15	20	25																																																																												
8. Curriculum development assistance																																																																																	
Consultations	20	35	50	65	80																																																																												
Workshops and conferences	5	10	15	20	25																																																																												
9. Materials developed (titles)	25	50	60	70	85																																																																												
<p>Inputs: Aid financing (AID) Regional and Specialty Training Training Service Agencies (TSA's) Leadership Consultations Curriculum development stimulus and guidance Management of Resources Professional Competence</p>	<p>At least 3 STSA's and one STSA's will be selected and functioning by June 1979.</p>	<p>Financial records and reports. Administrative files and reports. TSA work plans and reports.</p>	<p>Assumptions for providing inputs: There are American and international organizations that have the capability; experience and interest to become effective Training Service Agencies.</p>																																																																														

Chart XVII

DS/POP CURRENT ESTIMATE
OF THE RELATIVE LEVEL OF INPUTS
OF AID BILATERAL AND CENTRALLY
FUNDED POPULATION/FP ASSISTANCE 1/ 2/

1/ Level of Inputs are relative to each geographic region only and are based on FY 78 figures.

2/ This chart excludes IPPF and UNFPA inputs.

Africa Region

<u>Country</u>	<u>AID Bilateral Assistance</u>	<u>Centrally Funded Pop/FP Assistance</u>
Benin	BN	L
Botswana*	H	M
Burundi	N	N
Cameroon*	L	L
Cent. AFR Emp	BN	N
Chad	N	N
Congo	N	N
Ethiopia	N	M
Gabon	N	N
Gambia, The	N	L
Ghana*	L	M
Ivory Coast	BN	N
Kenya*	L	H
Lesotha*	BN	L
Liberia	L	L
Madagascar	N	N
Malawi	BN	N
Mali	BN	L
Mauritania	N	N
Maritius	N	M
Niger	N	N
Nigeria*	N	L
Rwanda	N	N
Senegal	L	L
Sierra Leone	BN	L
Somalia	BN	N
Sudan	BN	M
Swaziland*	BN	N
Tanzania	H	L
Togo	M	L
Upper Volta	N	N
Zaire	BN	L
Zambia	BN	L

Asia Region	AID Bilateral Assistance	Centrally Funded Pop/FP Assistance
Bangladesh*	M	H
Burma	N	N
India*	BN	L
Indonesia*	H	H
Korea	BN	H
Malaysia	N	L
Nepal	L	M
Pakistan*	L	M
Philippines*	M	H
Singapore	N	N
Sri Lanka	BN	L
Taiwan	N	N
Thailand*	H	H
Near East Region		
Afghanistan	L	L
Algeria	N	N
Egypt	M	M
Iran	N	L
Jordan	L	L
Lebanon	N	N
Moroeco	M	M
Syria	BN	L
Tunisia*	H	H
Turkey	N	L
Yemen Arab	BN	N
Latin America & Caribbean Region		
Argentina	N	L
Barbados	N	L
Bolivia	BN	L
Brazil*	N	H
Chile	N	H
Colombia*	N	H
Costa Rica	M	H
Dom. Republic*	BN	M
Ecuador	N	M
El Salvador	H	H
Guatemala	H	H
Guyana	N	N
Haiti	H	H
Honduras*	L	M
Jamaica	H	M
Mexico*	N	H
Nicaragua	M	M

Latin America & Caribbean Region (Continues)

	<u>AID Bilateral Assistance</u>	<u>Centrally Funded Pop/FP Assistance</u>
Panama	M	L
Paraguay	M	M
Peru	M	M
Uruguay	N	L
Venezuela	N	L
Other Caribbean	N	M

Key

- N - No Input
- BN - Assistance with No Pop/FP Input
- L - Assistance with Low Pop/FP Input
- M - Assistance with Moderate Pop/FP Input
- H - Assistance with High Pop/FP Input
- * - Priority Country for Centrally Funded Activities based on Total Pop/FP Needs

AID Population Program Assistance

Family Planning Training of Paramedics Auxiliary & Community
Personnel (PAC)

-Attribution of Requested Funds, FY 1979-

<u>DS/POP Summary</u>	<u>Total Funding</u> (in \$ thousands)	<u>PAC Tng</u>	<u>%</u>
Goal 1 - Demography	\$11.280	-0-	-
Goal 2 - Policy Development	5.600	-0-	-
Goal 3 - Research	13.345	345	5%
Goal 4 - Family Planning Services	50.125	3509	7%
Goal 5 - Information & Education	5.300	-0-	-
Goal 6 - Training/Institutions	9.935	4272	43%
Africa Region	8.870	2927	33%
Latin America Region	6.150	308	5%
Asia Region	38.440	769	2%
Near East Region	3.955	237	6%
UNFPA	30.000	5,400	18%
Others	<u>2,000</u>	-	-
OVERALL TOTAL	\$185.000	17,967	10%

5C(2) - PROJECT CHECKLIST *

A. GENERAL CRITERIA FOR PROJECT.

1. App. Unnumbered; FAA Sec. 653(b)

(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 plus 10%)?

Regular AID Budget Process

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

Yes

3. FAA Sec. 611(a)(2). If further legislative acting 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?

N/A

4. FAA Sec. 611(b); App. Sec. 101. If for water or water-related land resource construction, has project met the standards and criteria as per Memorandum of the President dated Sept. 5, 1973 (replaces Memorandum of May 15, 1962; see Fed. Register, Vol. 38, No. 174, Part III, Sept. 10, 1973)?

N/A

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

N/A

6. FAA Sec. 209, 619. 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. If assistance is for newly independent country, is it furnished through multilateral organizations or plans to the maximum extent appropriate?

N/A

7. FAA Sec. 601(a); (and Sec. 201(f) for development loans). 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.

N/A

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

N/A

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

To be determined in consultation with U.S. Embassies/USAIDs

10. FAA Sec. 612(d). Does the U.S. own excess foreign currency and, if so, what arrangements have been made for its release?

AID regulations will apply in appropriate countries

B. FUNDING CRITERIA FOR PROJECT

1. Development Assistance Project Criteria

- a. FAA Sec. 102(c); Sec. 111; Sec. 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, spreading investment out from cities to small towns and rural areas; and (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?

N/A

* Indicate Yes, No, or N.A. (not applicable) or "See Comments". Use the last page for comments; add extra page, if necessary.

b. FAA Sec. 103, 103A, 104, 105, 106, 107. Is assistance being made available /Include only applicable paragraph -- e.g., A, B, etc. -- which corresponds to source of funds used. If more than one funds source is used for project, include relevant paragraph for each fund source. N/A

(1) /T03/ for agriculture, rural development or nutrition, if so, extent to which activity is specifically designed to increase productivity and income of rural poor; /T03A/ if for agricultural research; is full account taken of needs of small farmers; N/A

(2) /T04/ for population planning or health; if so, extent to which activity extends low-cost, integrated delivery systems to provide health and family planning services, especially to rural areas and poor; embodied in project.

(3) /T05/ 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; N/A

(4) /T06/ for technical assistance, energy, research, reconstruction, and selected development problems; if so, extent activity is:

(a) technical cooperation and development, especially with U.S. private and voluntary, or regional and international development, organizations; N/A

(b) to help alleviate energy problem: N/A

(c) research into, and evaluation of, economic development processes and techniques; N/A

(d) reconstruction after natural or manmade disaster; N/A

(e) for special development problem, and to enable proper utilization of earlier U.S. infrastructure, etc., assistance; All for population & family planning

(f) 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. N/A

(5) /T07/ by grants for coordinated private effort to develop and disseminate intermediate technologies appropriate for developing countries. N/A

c. FAA Sec. 110(a); Sec. 208(e). Is the recipient country willing to contribute funds to the project, and in what manner has or will it provide assurances that it will 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)? To be determined.

d. FAA Sec. 110(b). Will grant capital assistance be disbursed for project over more than 3 years? If so, has justification satisfactory to Congress been made, and efforts for other financing. No

e. FAA Sec. 207; Sec. 113. Extent to which assistance reflects appropriate emphasis on: (1) encouraging development of democratic, economic, political, and social institutions; (2) self-help in meeting the country's food needs; (3) improving availability of trained worker-power in the country; (4) programs designed to meet the country's health needs; (5) other important areas of economic, political, and social development, including industry; free labor unions, cooperatives, and Voluntary Agencies; transportation and communication; planning and public administration; urban development, and modernization of existing laws; or (6) integrating women into the recipient country's national economy. (1), (2), (5) N/A (3) & (4) Embodied in project

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 civic education and training in skills required for effective participation in governmental and political processes essential to self-government. N/A

g. FAA Sec. 201(b) (2)-(4) and -(8); Sec. 201(a); Sec. 211(a)(1)-(3) and -(8). 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; or of educational or other institutions directed

toward social progress? Is it related to and consistent with other development activities, and will it contribute to realizable long-range objectives? And does project paper provide information and conclusion on an activity's economic and technical soundness?
Will contribute in general way

h. FAA Sec. 201(b)(6); Sec. 211(a)(5), (6). Information and conclusion on possible effects of the assistance on U.S. economy, with special reference to areas of substantial labor surplus, and extent to which U.S. commodities and assistance are furnished in a manner consistent with improving or safeguarding the U.S. balance-of-payments position. N/A

2. Development Assistance Project Criteria (Loan only)

a. FAA Sec. 201(b)(1). Information and conclusion on availability of financing from other free-world sources, including private sources within U.S. N/A

b. FAA Sec. 201(b)(2); 201(d). Information and conclusion on (1) capacity of the country to repay the loan, including reasonableness of repayment prospects, and (2) reasonableness and legality (under laws of country and U.S.) of lending and relending terms of the loan. N/A

c. FAA Sec. 201(e). If loan is not made pursuant to a multilateral plan, and the amount of the loan exceeds \$100,000, has country submitted to AID an application for such funds together with assurances to indicate that funds will be used in an economically and technically sound manner? N/A

d. FAA Sec. 201(f). Does project paper describe how project will promote the country's economic development taking into account the country's human and relationship between immediate objectives of the project and overall economic development? N/A

e. FAA Sec. 202(a). Total amount of money under loan which is going directly to private enterprise, is going to intermediate credit institutions or other borrowers for use by private enterprise, is being used to finance imports from private sources, or is otherwise being used to finance procurements from private sources? N/A

f. 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? N/A

3. Project Criteria Solely for Security Supporting Assistance

FAA Sec. 531. How will this assistance support promote economic or political stability? N/A

4. Additional Criteria for Alliance for Progress

Note: Alliance for Progress projects should add the following two items to a project checklist.

a. FAA Sec. 251(b)(1), -(8). Does assistance take into account principles of the Act of Bogota and the Charter of Punta del Este; and to what extent will the activity contribute to the economic or political integration of Latin America? N/A

b. FAA Sec. 251(b)(8); 251(h). For loans, has there been taken into account the effort made by recipient nation to repatriate capital invested in other countries by their own citizens? Is loan consistent with the findings and recommendations of the Inter-American Committee for the Alliance for Progress (now CEPACIES, the Permanent Executive Committee of the OAS) in its annual review of national development activities? N/A

ADDITIONAL COMMENTS:

5C(3) - STANDARD ITEM CHECKLIST*A. Procurement

1. FAA Sec. 602. Are there arrangements to permit U.S. small business to participate equitably in the furnishing of goods and services financed? Yes
2. FAA Sec. 604(a). Will all commodity procurement financed be from U.S. except as otherwise determined by the President or under delegation from him? Yes
3. FAA Sec. 604(d). If the cooperating country discriminates against U.S. marine insurance companies, will agreement require that marine insurance be placed in the U.S. on the commodities financed? To be determined by SER/CM
4. FAA Sec. 604(e). If offshore procurement of agricultural commodity or product is to be financed, is there provision against such procurement when the domestic price of such commodity is less than parity? N/A
5. FAA Sec. 608(a). Will U.S. Government excess personal property be utilized wherever practicable in lieu of the procurement of new items? Yes
6. MMA Sec. 901(b). Does this comply with the requirement that at least 50 percent of the gross tonnage of commodities (computed separately for dry bulk carriers, dry cargo liners, and tankers) financed shall be transported on privately owned U.S. -flag commercial vessels to the extent that such vessels are available at fair and reasonable rates? N/A
- FAA Sec. 521. 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 facilities of other Federal agencies will be utilized, are they particularly suitable, not competitive with private enterprise, and made without undue interference with domestic programs? Yes
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

B. Construction

1. FAA Sec. 601(d). If a capital (i.e., construction) project, are engineering and professional services of U.S. firms and their affiliates to be used to the maximum extent consistent with the national interest? N/A
2. FAA Sec. 511(c). If contracts for construction are to be financed, will they be let on a competitive basis to the maximum extent practicable? N/A
3. FAA Sec. 420(k). If for construction of productive enterprise, will aggregate value of assistance to be furnished by the U.S. not exceed \$100 million? N/A

C. Other Restrictions

1. FAA Sec. 201(b). If development loan, is interest rate at least 2% per annum during grace period and at least 3% per annum thereafter? N/A
2. FAA Sec. 301(d). If fund is established solely by U.S. contributions and administered by an international organization, does Comptroller General have audit rights? N/A
3. FAA Sec. 420(h). Do arrangements preclude promoting or assisting the foreign aid projects or activities of Communist-Bloc countries, contrary to the best interests of the U.S.? Yes
4. FAA Sec. 416(f). Is financing not permitted to be used, without waiver, for purchase, long-term lease, or exchange of motor vehicle manufactured outside the U.S. or guaranty of such transaction? Yes

5C(3) - STANDARD ITEM CHECKLIST (continued)

C. Other Restrictions

5. Will arrangements preclude use of financing:

a. FAA Sec. 114. to pay for performance of abortions or to motivate or coerce persons to practice abortion? Yes

b. FAA Sec. 820(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. App. Sec. 103. to pay pensions, etc. for military personnel? Yes

f. App. Sec. 106. to pay U.N. assessments? Yes

g. App. Sec. 107. to carry out provisions of FAA Section 209(d) and 251(h)? (transfer to multilateral organization for lending). Yes

h. App. Sec. 501. to be used for publicity or propaganda purposes within U.S. not authorized by Congress? Yes

ADDITIONAL COMMENTS:

ENVIRONMENTAL THRESHOLD DETERMINATION

TO: BA/DSB

FROM: DS/POP/TT, Gerald F. Winfield

SUBJECT: Environmental Threshold Determination

Project Title: FP Training for Paramedics/Auxiliaries

Project #: 932-0644

Specific Activity (if applicable)

REFERENCE: Initial Environmental/Examination (IEE) contained in attached paper dated 12-4-78

I recommend that you make the following determination:

- X 1. The proposed agency action is not a major Federal action which will have a significant effect on the human environment.
- 2. The proposed agency action is a major Federal action which will have a significant effect on the human environment, and:
 - a. An Environmental Assessment is required; or
 - b. An Environmental Impact Statement is required.

The cost of and schedule for this requirement is fully described in the referenced document.

 3. Our environmental examination is not complete. We will submit the analysis no later than _____ with our recommendation for an environmental threshold decision.

Approved: _____

Disapproved: _____

Date: _____

IMPACT IDENTIFICATION AND EVALUATION FORM

Impact Areas & Sub-areas^{1/} Impact^{2/}

A. LAND USE

- 1. Changing the character of the land thru:
 - a. Increasing the population..... N
 - b. Extracting natural resources..... N
 - c. Land clearing..... N
 - d. Changing soil character..... N
- 2. Altering natural defenses..... N
- 3. Foreclosing important uses..... N
- 4. Jeopardizing man or his works..... N
- 5. Other factors _____

B. WATER QUALITY

- 1. Physical state of water..... N
- 2. Chemical and biological states..... N
- 3. Ecological balance..... N
- 4. Other factors _____

C. ATMOSPHERIC

- 1. Air additives..... N
- 2. Air pollution..... N
- 3. Noise pollution..... N
- 4. Other factors _____

D. NATURAL RESOURCES

- 1. Diversion, altered use of water.... N
- 2. Irreversible, inefficient commitments N
- 3. Other factors _____

E. CULTURAL

- 1. Altering physical symbols..... N
- 2. Dilution of cultural traditions..... N
- 3. Other factors _____

Impact Areas & Sub-areas^{1/} Impact^{2/}

F. SOCIOECONOMIC

- 1. Changes in economic/employment patterns..... N
- 2. Changes in population..... N
- 3. Changes in cultural patterns..... N
- 4. Other factors _____

G. HEALTH

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

H. GENERAL

- 1. International impacts..... N
- 2. Controversial impacts..... N
- 3. Larger program impacts..... N
- 4. Other factors _____

I. OTHER POSSIBLE IMPACTS (not listed above)

FOOTNOTES:

1/ See Explanatory Notes for this form.

2/ Use the following symbols:

- N- No environmental impact
- L- Little environmental impact
- M- Moderate environmental impact
- H- High environmental impact
- U- Unknown environmental impact

Additional comments: