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UNITED STATES INTERNATIONAL DEVELOPMENT COOPERATION AGENCY

AGENCY FOR INTERNATIONAL DEVELOPMENT

WASHINGTON, D.C. 20523

PROJECT PAPER

BURMA

PRIMARY HEALTH CARE II

482-0004

1983

UNCLASSIFIED

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AGENCY FOR INTERNATIONAL DEVELOPMENT

PROJECT DATA SHEET

1. TRANSACTION CODE

A

A = Add
C = Change
D = Delete

Amendment Number

DOCUMENT CODE

3

COUNTRY/ENTITY
BURMA

5. PROJECT NUMBER
482-0004

6. BUREAU/OFFICE
ASIA

5. PROJECT TITLE (maximum 40 characters)
PRIMARY HEALTH CARE II

6. PROJECT ASSISTANCE COMPLETION DATE (PACD)

MM DD YY
01 31 87

7. ESTIMATED DATE OF OBLIGATION
(Under "B." below, enter 1, 2, 3, or 4)

A. Initial FY 83 B. Quarter 3 C. Final FY 85

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

A. FUNDING SOURCE	FIRST FY 83			LIFE OF PROJECT		
	B. FX	C. L/C	D. Total	E. FX	F. L/C	G. Total
AID Appropriated Total						
(Grant)	(5100)	()	(5100)	(10000)	()	(10000)
(Loan)	()	()	()	()	()	()
Other U.S.						
1. PROJECT FUND ACCOUNT		1867	1867		4533	4533
2. (AID)						
Host Country		2976	2976		13175	13175
Other Donor(s)	4795	681	5476	20583	2043	27626
TOTALS	9895	524	15419	30583	19751	50334

9. SCHEDULE OF AID FUNDING (\$000)

A. APPROPRIATION	B. PRIMARY PURPOSE CODE	C. PRIMARY TECH. CODE		D. OBLIGATIONS TO DATE		E. AMOUNT APPROVED THIS ACTION		F. LIFE OF PROJECT	
		1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan
(1) HE	533-B	510				5100		10000	
(2)									
(3)									
(4)									
TOTALS						5100		10000	

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

530 350 440

11. SECONDARY PURPOSE CODE

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

A. Code DFI NUTR TNG
B. Amount

13. PROJECT PURPOSE (maximum 480 characters)

To Expand rural health services coverage in Burma by Volunteer Health Workers, with increased emphasis on quality of services through improved pre-service and in-service training in 140 rural townships. To introduce Family Health Counseling service as integral part of maternal and child health care services in Burma.

14. SCHEDULED EVALUATIONS

Interim MM YY MM YY Final MM YY
01 85 06 86

15. SOURCE/ORIGIN OF GOODS AND SERVICES

000 941 Local Other (Specify) 935

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

17. APPROVED BY

Signature: Richard B. Nelson
Title: Richard B. Nelson Acting AID Representative

Date Signed: 03 06 83

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

MM DD YY

ABBREVIATIONS

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

GLOSSARY

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

I. Summary and Recommendation

It is recommended that the Agency for International Development (A.I.D.) provide a grant of 10 million U.S. dollars to the Socialist Republic of the Union of Burma (SRUB) to carry out the Primary Health Care II Project described herein. AID and the SRUB have already earmarked Kyat 34 million in the Project Fund Account (AID) for this project, to augment the contribution made by the Department of Health from its regular budget.

A. Purpose

The Purpose of the Project is to assist the SRUB Department of Health to a) expand the village volunteer health services system, b) improve the quality of health services provided, and c) introduce Family Health Counseling into the Department's Maternal and Child Health (MCH) services. The Project is intended to reduce the following health problems of rural villagers: diarrheal disease, malnutrition, communicable diseases, inadequate obstetrical care, and the lack of family health counseling services. Family health counseling focuses on the problems of mothers and children with special emphasis on pregnancy, childbirth, parentcraft, child development, fertility regulation, and infertility.

B. Outputs

The principal outputs of the Project which will lead to achievement of the Purpose are:

1. Expanded numbers and improved training of Volunteer Health Workers (VHWs)
2. An equipment and supply system to support VHWs on a sustained basis.
3. Production of improved health education and training materials.
4. An effective health information system
5. A strengthened DOH management and supervision system
6. Improved supervision of VHWs by rural health center staffs
7. An expanded disease surveillance and monitoring system at the village level which can measure the incidence of diarrheal disease, communicable diseases and malnutrition.
8. The provision of family health counseling services to women of reproductive age at hospitals, clinics, and RHCs.

C. Analyses

Based on the experience gained to date in PHC I, and on the analyses conducted as part of preparation of this Project, AID/Burma concludes that the Project is feasible.

D. Implementation

The Government of the Socialist Republic of the Union of Burma (SRUB) will be the Grantee. The Department of Health, Ministry of Health, will be the implementing agency. Responsibilities and procedures for implementing this Project have been well established during the implementation of PHC I. The single new element in this project, Family Health Counseling, will involve the participation of some new institutions and medical staff, but all under the administration of the Department of Health.

E. Waivers

In order to effect substantial cost savings and to ensure compatibility between AID-financed and other donor-financed commodities, a code 935 source/origin waiver (for commodities and possibly for shipping) and sole source waiver to permit procurement from UNICEF will be requested at the time of project authorization. (Approximately \$2.0 million). Similar waivers were approved for Primary Health Care I.

F. Statutory Requirements

Both project-specific and general statutory requirements have been met (see Annex H).

G. Issues

PID issues have been satisfactorily addressed (see technical, social and financial analyses and Annex B.)

SOCIALIST REPUBLIC OF THE
UNION OF BURMA

INDIA

Kachin State

CHINA

Approximate Geographic Coverage by Township and Groups of Townships

PHC I 

PHC II 

(Proposed)

Sagaing Division

Shan State

BANGLADESH

Chin State

LAC

Arakan State

Magwe Division

Mandalay Division

THAILAND

Kayah State

Tenasserim Division

THAILAND

Pegu Division

0 50 100
Miles

Mingoon Division

Karen State

Irrawaddy Division

Mon State

THAI

TABLE ONE

SELECTED HEALTH AND SOCIAL INDICATORS IN BURMA

Crude Death Rate	11 per 1000 (1976)
Infant Mortality Rate	140 per 1000 (1970 est.)
Age 1 - 4 years Mortality Rate	11 per 1000
Proportion of Deaths in Children below 5 years	25% of all <u>DEATHS</u> (1977)
Maternal Mortality Rate	1.4 per 1000 (1982 est.)
Life Expectancy at Birth	Female: 60 years (1976) Male : 56 years (1976)
Crude Birth Rate	37 per 1000
Total Fertility Rate	5.5 (1975)
Population Growth Rate	2.4% per year (1976)
Access to Safe Water	Rural 14% (1978) Urban 31% (1978)
Access to Adequate Sanitation	12% (1978)
Malnutrition in 1 - 3 yr. old children <u>1/</u>	
Severe	2%
Moderately severe	12%
Low Birthweight infants <u>2/</u>	22% (1978)
Adult Literacy	67%
Per Capita Income	\$170
Population Density	110 per sq. mile

1/ Jelliffe & Jelliffe, Consultant Report (1980)

2/ Tin U & Kyaw Myint, Perinatal Mortality Study (1981)

4 Health Services Delivery

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

The existing network of health facilities includes referral and general hospitals at national and Division/State levels offering services of medical specialists. There are township level hospitals staffed by general medical officers. Towns and cities are served by urban health centers and maternal and child health centers, while rural basic health services are provided by Rural Health Centers (RHCs) and RHC sub-centers staffed by para-professionals and Station Hospitals are manned by medical officers.

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

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

In addition, a number of specialized and generally vertical public health programs have been developed including vector-borne disease control (malaria, dengue hemorrhagic fever, filariasis and Japanese B encephalitis), leprosy, tuberculosis, venereal disease and trachoma control programs, environmental sanitation programs and the newly developed expanded program for immunization. Contraceptive services have not previously been offered in the Government programs. Up to 40 percent of hospitalizations related to pregnancy are for the complications of abortion. Most of these programs are operating throughout the country as necessary, under the direction of the Health Director in each Division or State.

Burma has an internal capability for production of needed health manpower. In addition to para-professional training programs, there are three medical schools which offer postgraduate training in the major medical specialties including preventive medicine. Training of health assistants was discontinued in 1973 with the intention that HAs would gradually be replaced by physicians in some strategic health centers. However, it proved impractical to assign physicians to RHCs so training of HAs has been resumed, but with a revised curriculum. Presently, Public Health Supervisors Grade I are being upgraded to HAs with one year of training. A decision is expected soon on the resumption of HA training.

Of the 7,864 doctors in Burma (1980 estimate) over half are working in the private sector, primarily because of a dearth of available positions in government service. The same is true to a lesser extent for nurses and midwives. In addition to allopathic practitioners, there is a large number of traditional healers. Indigenous practitioners are discussed more fully in the social analysis.

B. The People's Health Programme

In 1978, the Government of the Socialist Republic of the Union of Burma (SRUB) embarked on a new health care initiative, the People's Health Programme, with the first phase (1978-82) now coming to a close. The second People's Health Programme (PHP II) (1983-86) reflects the revised Burmese strategy -- a better balance between preventive and curative care -- to reduce morbidity and mortality, especially among infants and children.

1. Objectives

The major priorities of the PHP II (1983-86) are:

- a. To provide expanded basic health services in rural townships, thereby narrowing the gap between urban and rural areas;
- b. To improve environmental health by increasing access to potable water, especially in dryland areas, and by improving sanitation and waste disposal facilities;
- c. To involve the community in identifying its health problems and needs. This involves the use of local resources to support the availability and use of health services, thereby fostering self-reliance;
- d. To promote preventive and curative services, with priority accorded to preventive measures, in the control of communicable diseases;
- e. To provide adequate and essential medical care to prevent or reduce mortality due to disease and injuries; and,
- f. To give priority to health problems affecting mothers and children and to effect measures that will address these problems. 1/

In order to meet these objectives, service and support programs have been identified. The service programs for PHP II include:

- (1) Community Health Care
- (2) Disease Control
- (3) Environmental Health
- (4) Hospital Care

1/ Including Family Health Counseling

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Support programs include:

- (1) Laboratory Services and Food and Drug Quality Control
- (2) Production, Supply/Logistics and Maintenance and Repair
- (3) Medical Equipment Repair and Maintenance
- (4) Health Education

The collection and analysis of health data, as well as medical and health related research, are emphasized in PHP II, and are the responsibility of the Department of Health's Information Service.

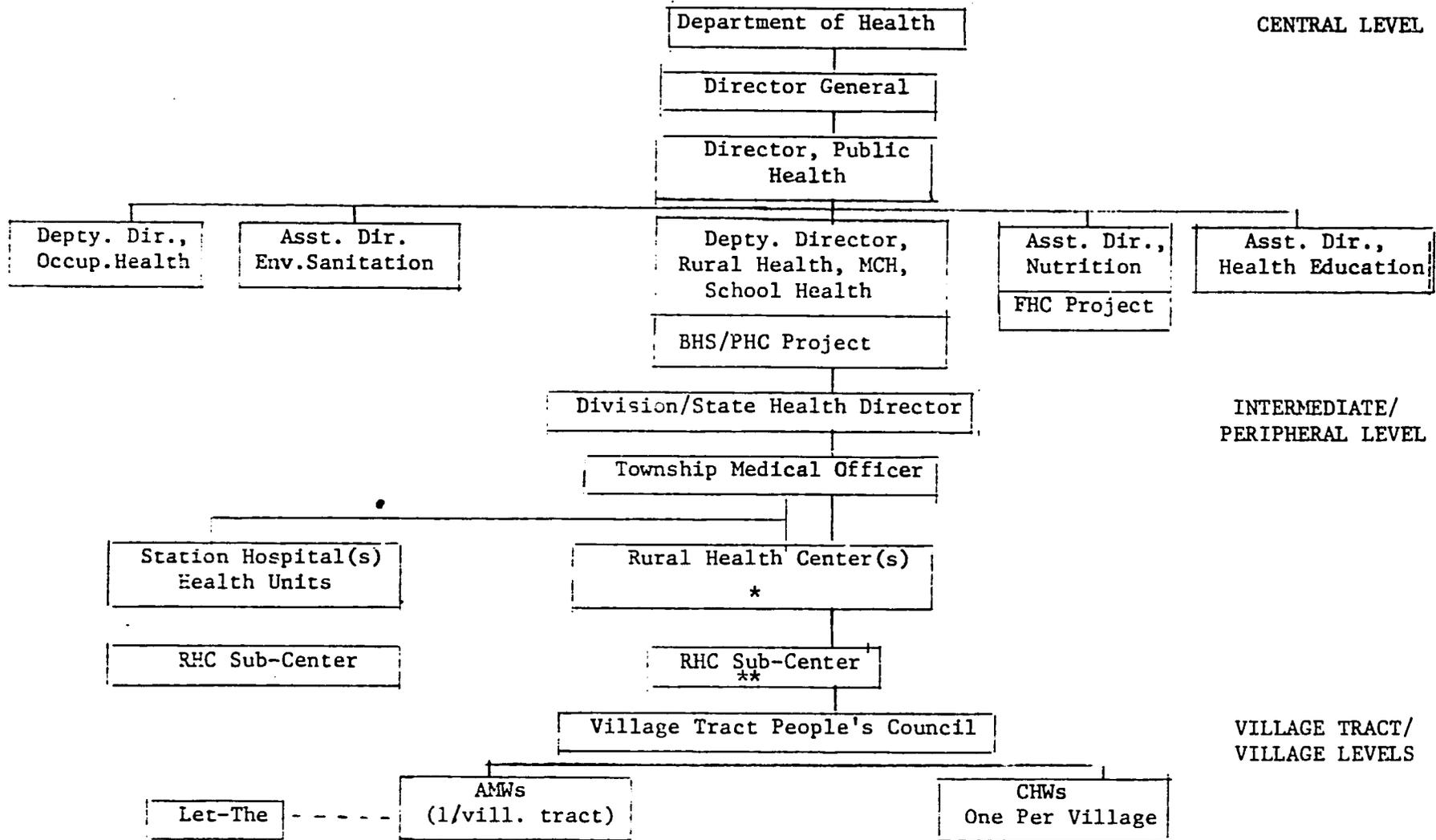
2. Organization of the Department of Health

The pyramidal organization of Burma's health sector reflects the country's general administrative structure. The country is divided into seven States and seven Divisions. The Divisions are the administrative units in the central plains areas, whose population consists of ethnic Burmese. The States are inhabited primarily by ethnic minority groups. Burma's 14 States and Divisions are sub-divided into 314 rural and urban townships and 13,756 Village Tracts. Each Village Tract is comprised of about five villages.

The Ministry of Health, ultimately responsible for the nation-wide delivery of health services, is comprised of four Departments: Health (DOH), Medical Research, Medical Education, and Sports and Physical Education. The DOH is charged with the design and implementation of the People's Health Programme. At the Central level, health care services delivery is limited to tertiary care hospitals and urban clinics mostly in Rangoon and Mandalay (See Organizational Chart).

At the State/Division level, health services are administered by the State/Division Health Director with the assistance of public health and other personnel. At this level, curative services delivery is provided on a referral basis by the 14 State/Division Hospitals staffed by medical specialists.

BURMESE ORGANIZATION FOR THE DELIVERY OF PUBLIC HEALTH SERVICES



-7-

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

** RHC Sub-Centers are staffed by Midwives.

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The Township Medical Officer (TMO) is in charge of the Township Health Department and in some cases is assisted by a Township Health Officer who supervises public and community health programs throughout the Township. While curative services are provided through Township Hospitals, which are staffed by general medical officers and have a 16-150 beds, the Township Health Department also implements the Basic Health Center network.

Basic Health Services (BHS) represent the most peripheral level of Burma's formal rural health sector -- that is, the lowest level of the health delivery system which is financed by the Government. In rural areas, Basic Health Services are provided by a network of 195 Station Hospitals plus 1077 Rural Health Centers and 4308 Sub-centers. Station Hospitals, whose staff includes a medical officer, usually have about 16-25 beds and provide curative services. Rural Health Centers (RHC) provide outpatient health care, and are staffed by para-professionals including a health Assistant, one Lady Health Visitor, one Midwife, and one to four Public Health Supervisors. A RHC has four (4) sub-centers each with a midwife.

When a Station Hospital is constructed in an area being served by a rural health center, the Health Assistant is transferred to another area without such a professional, and the Station Hospital's medical officer assumes a supervisory role for the RHC as well. Like Station Hospitals, the service area for RHC's is a portion of a Township, consisting on the average of approximately 12 Village Tracts.

The RHC is responsible for the provision of preventive services, and an array of curative health services. It also acts as a referral mechanism to the Township level. Making referrals, however, is often difficult unless the RHC is near the Township Hospital. Therefore, Health Assistants are charged with providing and supervising most curative medical work in Village Tracts.

The final rung on the ladder of Basic Health Services in Burma is the Rural Health Sub-Center. For each RHC there are four satellite sub-centers staffed by a midwife, and in some instances, a public health supervisor. Sub-centers are often located in the homes of the midwives.

The RHC and sub-center staffs make regular visits to villages. They do not wait passively for people to come to them. Normally the centers are closed three days per week in order for the staff to make their visits. Where there are VHVs, the center staffs visit them to check on their work and to provide advice.

Despite the existence of the Basic Health Services in Burma, and the outreach service described above, rural villages still receive inadequate health care. Large numbers of Village Tracts are still not served by Basic Health Services (RHCs and sub-centers). In some instances, RHC staff are overburdened and short of equipment and supplies, thus limiting the efficiency of the system in meeting health needs. On average, each RHC serves a population of 22,000. Traditionally, preventive health activities have been over-shadowed by curative activities.

3. The Community Health System

To provide health services equitably to rural dwellers, Burma conceived a new tier of health services termed primary health care, to be provided by community-supported volunteer health workers (VHW). Two new types of workers have been deployed at the village level and village tract levels: Community Health Workers (CHW) and Auxiliary Midwives (AMW). In addition, a third component of this health workers scheme involves the training of Let-Thes, or traditional birth attendants (TBA). Usually elderly, TBAs have been serving their communities in the absence of other obstetrical care. All three categories of Workers are referred to incorrectly as Volunteer Health Workers or VHWs. Only the CHW's and AMW's are truly "new" Volunteer Health Workers. TBAs have existed for centuries and receive remuneration for their services.

Administratively, AMW's and CHW's are recruited by and are responsible to the lowest government administrative unit, the Village Tract People's Council. For all technical matters they are supported by the DOH health system and trained by and supervised by Township and RHC staffs, who have been trained for that function by their respective State/Division Training Teams and provided with equipment and initial expendable supplies by the DOH. Funds for resupply and other needs are the responsibility of the Village Tract People's Council.

Community participation in primary health care implementation is encouraged by the Burmese Government.

Village and Village Tract People's Councils are actively involved through their Health and Social Welfare committees. There is realistic feedback from the People's Councils back up the chain of program management responsibility as to the progress of implementation. Such feedback is valuable in refining intervention strategy.

Major Auxiliary Midwife activities are:

- Antenatal and postnatal care;
- Home delivery;
- Communicable disease surveillance;
- Vital health statistics reporting;
- Assistance with immunization, and,
- Minor treatment, management of emergencies and referral of severe cases;
- Nutrition surveillance;
- Assistance with Family Health Counseling

Community Health Workers are charged with:

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

An objective of the Second People's Health Programme (1983-86) is to have at least one auxiliary midwife or midwife in each Village Tract, and one community health worker in 45% of the villages in the country. Such deployment is an innovative and low cost approach to primary health care for all Burmese.

C. Performance to Date

Although concrete evidence of the impact which the village volunteer program is having on mortality and morbidity is not yet available, the program is functioning reasonably well. Evidence to that effect has been obtained by numerous observers including AID/Burma staff from visits to more than fifty townships, from the PHC I Mid-Term Evaluation team, the PHC II project paper design team visits to 11 sites, PHC I consultants, DOH reports and staff feedback and WHO/UNICEF staff observations. The village volunteers are being recruited, trained and supervised; they are working; drugs and supplies are generally being replaced as needed and paid for from villagers' contributions; and DOH headquarters staff are striving to improve the program. A project consultant put it this way: "...four years after the start of the program (1977) it is evident that thousands of unpaid villagers are providing health services to their neighbors - preventing and curing illnesses, promoting better health practices; delivering babies. The success we are describing may thus be measurable only in program, rather than impact terms, but its existence is undeniable." ^{1/} One thing is clear; if there were no "program" success there could certainly be no impact.

^{1/} Don Chauls - Volunteers Who Work, (1982) (unpublished paper)

1. Findings of the PHC I Mid-Term Evaluation

The April 1982 Mid-Term Evaluation of Primary Health Care I recorded a number of important observations. In terms of project implementation, the evaluation confirmed that deployment of voluntary health workers had met the targets established but that the preventive/curative ratio of health worker activity needed attention and the quality of training needed improvement. Several suggestions for improvement in training were made including preparation of new materials and teaching methods, more in-service training and the firm establishment of the State/Division Training Teams. Supervision by RHC staff of voluntary health workers was found to be weak. The heavy commodity input by AID and other donors was noted as well as the problems of re-supply of VHWs, stemming from domestic production shortages. The development of a village-based, nutrition surveillance program, with the VHW utilizing existing organized groups of volunteers, was suggested. The need for MCH services to include family health counseling services was highlighted in view of the increasing number of reported septic abortions. Finally, data generated by the Health Information Service was considered inadequate for accurate project planning, monitoring and evaluation purposes.

The above findings have been taken into serious consideration in the formulation of this Project, particularly suggestions on training, both pre- and in-service; training curricula and methods; a reduction in the proportion of AID-financed commodities; continued emphasis on nutrition; and the addition of family health counseling services.

2. Other Findings

The AID/Burma staff has now observed the Burmese primary health care program in over fifty townships and have talked with many volunteer workers who are enthusiastic and working. Studies indicate that VHW's average two hours per day in health activities^{1/} and that they are being resupplied from local funding. AID/Burma staff have discovered that almost every Village Tract has sufficient funds for drug re-supply and that pharmaceuticals are generally available in the open market. Volunteer health workers' success with environmental sanitation, however, varies from excellent to poor. Such a variance in performance is a reflection both of worker training and the degree of cooperation of the local Village Tract People's Council.

The Training Division, through the Health Assistants Training School (HATS), is striving to strengthen the training of VHWs via both pre-service and more in-service courses. The prospect of full-time, well-functioning State/Division Training Teams is positive. Their work is crucial to and will affect both improved training and supervision of VHW's.

1/ Dr. Aung Tun Thet and Myint Thaug,
Time Utilization of Voluntary Health Workers (1982)

D. Project Objectives

The Department of Health and AID/Burma have reviewed the objectives and accomplishments of primary health care activities in Burma in the course of planning for the 1983-86 period. The AID Mid-Term Evaluation was focused on the Primary Health Care I project to evaluate progress and to identify areas of potential further assistance appropriate for a Primary Health Care II project.

The common goal of the People's Health Programme and PHC II, which supports the former, is to reduce morbidity and mortality among children under five years and among women of reproductive age. In support of that goal, the purpose of this project will be to assist the Department of Health a) expand the village volunteer health services system, b) improve the quality of services provided and c) introduce family health counseling into MCH services.

As described, the Department of Health's services extend downward only to Rural Health Centers and their sub-centers. While health center para-medical staffs do visit the outlying villages frequently, they cannot provide the kind of health service coverage required. From a cost standpoint it would be impossible for the DOH to recruit enough full time, paid para-medical staff to do the job.

Consequently, the Department opted in the People's Health Programme, to provide technical and some material support to the communities concerned to enable them to take responsibility for operating and funding their own first line primary health care program. The means for achieving the goal of extending effective health services to all villages is a community-based volunteer system. Other options would be less cost effective.

The project will, therefore, continue the work begun in PHC I by assisting the DOH to provide initial training and equipment to 8,200 CHWs^{1/}, 2,700 AMWs^{1/} and 12,000 TBAs to serve in their own villages in 140 rural Townships.

The Department is concerned that health services provided in the villages be appropriate to the setting and the capabilities of the volunteers and that they yield a measurable improvement in villagers' health status. Observations to date reveal that the knowledge and performance of the volunteer varies widely and that more attention should be paid to preventive and health education measures. The Project will address this performance objective (part B of the Purpose) by assisting the DOH assess VHW performance, analyze and revise training curricula and didactic methods, provide continuing in-service training to VHWs and staff and by improving the health information system.

^{1/} These numbers represent the AID supported portion of the total 16,400 CHW and 5,400 AMW. The remainder are supported by UNICEF.

Statistics reveal that pregnancy-related health problems are a significant obstacle to achieving the People's Health Programme's maternal and child health goals. The maternal mortality rate is estimated at 1.4 per 1000 live births; infant mortality, 140/1000 live births; and clinically diagnosed anemia among pregnant women, 68 per cent. Incidence of low birth weight babies delivered in three Rangoon hospitals in a 1978-1979 study ranged from 19.3 percent to 30.3 percent.^{1/} Many such babies are handicapped by impaired physical and mental development, often compounded by the diarrheal and other infections to which they are easy prey.

In a prospective study at Central Women's Hospital, Rangoon, from July 1980 to June 1981, ^{2/} the ratio of abortions to deliveries was 0.39. Of these abortions 18.5 percent were septic. Analysis of hospital deliveries in the states and divisions gave an abortion/delivery ratio of 0.42. Incidence of maternal deaths due to abortion is reported to be 2.1 per 1000 abortions in Rangoon hospitals; the number of maternal deaths, which occur outside government hospitals due to infected abortion is very high.

One finding of another prospective study at Central Women's Hospital revealed that infertility problems caused between one and two percent of gynecological visits to the out-patient department.

High rates of maternal and infant mortality and morbidity are associated with high parity, short birth intervals, pregnancies at either extreme of women's reproductive age span, and pregnancies with risk-elevating health conditions (poor nutritional status, infections, and a number of chronic diseases). Much of this morbidity and mortality is preventable.

In harmony with the goals of the People's Health Programme and Burma's participation in the global campaign for Health for All by the Year 2000, the Department of Health plans to introduce Family Health Counseling Services. The fertility regulation information and services to be offered will give couples safe, effective options for spacing their children and reducing the risks of pregnancy and childbirth. Since high incidence of maternal morbidity and mortality is linked to unplanned, ill-advised pregnancies, this component of family health counseling is an essential element of a quality MCH services program. The family health counseling program will also increase the capability to investigate and treat infertility and to investigate the prevalence of genetic disorders in the country. The Project will support the family health counseling initiative expressed as part C of the Project Purpose.

^{1/} Dr. Tin U and Kyaw Myint - Perinatal Mortality and Low Birth Weight Study - Burma (1981)

^{2/} Dr. Katherine Ba Thike - Septic Abortion at Central Women's Hospital (1981)

E. Project Outputs

Outputs expected from the Project may be grouped according to four identifiable but inter-related components as follows:

- VHW training, supply and deployment
- Health information systems and research
- DOH management and support system
- Family health counseling

Outputs associated with each component are described below:

1. VHW Training, Supply and Deployment:

a) Pre-service training: (8,200)CHWs, 2,700 AMWs and 12,000 TBAs will be trained and equipped to provide health services in 8,000 villages in 140 rural townships.

b) In-service training: 13,958 CHWs and 4,600 AMWs already at work will receive refresher or additional training during the project period. Approximately 5,592 Village Tract People's Councils and 140 Township People's Councils will receive one week orientation training on the basic objectives and fundamentals of the PHC program.

c) Improvement in training curricula and methods: Changes will be made to make pre-service training more effective. The training period for CHWs will be expanded from three weeks to four; more time will be devoted to practice; fewer subjects will be covered; there will be less emphasis on curative functions as opposed to preventive. The DOH training division will analyze the curriculum and make modifications as appropriate, assisted by Project consultants. Three DOH staff will receive training abroad in health education methods to expand the capacity of the Training Division.

A revised, task-oriented curriculum for a four week CHW training course will be prepared to replace the current three week course. High priority will be placed on training CHWs and AMWs to treat diarrheal disease and conduct nutritional surveillance and education through regular weighing of children under five years.

d) Training materials: Improved materials, including appropriate aids will be developed and distributed to Basic Health Services staff to assist them in training AMWs and CHWs to enable them in turn to explain their tasks to the community and Village Tract People's Councils. Emphasis will be on messages and materials to promote improved environmental sanitation practices, nutritional practices, diarrheal control, and reproductive health.

e) State and Division Training Teams: In the early stages of PHC I the teams (S/DTTs) were not formed or fully prepared to conduct VHW training as envisioned. The training task often fell upon the regular Township health staffs who were not prepared nor had time to devote to it. The S/DTTs are now approaching fully operational status and during this Project they will receive additional training to upgrade their skills. During PHC II the SRUB will establish and fund permanent positions. A permanent S/DTT coordinating unit will be established within the Training Division to strengthen planning, supervision and coordination of the teams' activities.

f) Equipment and Supplies: All VHWs (CHWs, AMWs and TBAs) will continue to receive supply kits, including appropriate drugs, upon graduation from pre-service training, as was done in PHC I. The contents of each kit are appropriate to the function of each category of VHW. Experience shows that the kits are properly used, durable equipment is well maintained and expendable supplies are replaced, paid for with community funds. Drug resupply is the responsibility of Village Tract People's Councils who can purchase from Cooperative Stores or from the open market with funds contributed by the community.

2. Health Information System and Research:

a) Health Information System: This Project will support a review by the DOH of the quality, quantity and timeliness of health data currently being reported, and uses made of the information. An improved system will be developed which will provide the DOH with information needed to monitor project progress, manage the project effectively and plan future programs. The system will include "process" information regarding the performance of the program managers, trainers and health care providers and "impact" information regarding changes in health status of the target population. This task will be facilitated by use of computer equipment provided under PHC I and by consultants and specialized staff training provided by this Project.

b) Research and Evaluation: The ongoing health information system described above will be supplemented by a series of special studies on both operational and technical subjects to provide the DOH with information required to manage effectively the Program. A list of proposed studies is included in Table Two for illustrative purposes.

3. DOH Management and Supervision:

a) Training: Upgrading of technical and management skills of DOH staff at central, Division/State and Township and RHC levels will be pursued via training courses abroad (long-term and short-term) and in-country. Training abroad will include maternal and child health, health system management/administration, biostatistics, epidemiology, environmental engineering, diarrheal disease control, and vector control.

RECOMMENDED AREAS FOR EVALUATIVE RESEARCH

I. Continuation of Studies Now Underway

- 1 - Periodic Repeat Rural Household Surveys on Morbidity, Mortality, and Health Care
- 2 - Evaluation by the Trainers of the Ability of VHW to Perform the Tasks Taught during Training
- 3 - Observational Study of the Time Utilization of Voluntary Health Workers and Basic Health Staff
- 4 - Repeat Survey on the Performance of TBA Three Years After Training
- 5 - Resurvey of Infant Feeding Practices and Nutritional Status of 0 - 3 Year-olds following Nutrition Education
- 6 - Hospital Based Study of Dietary Practices and Weight Gain during Pregnancy, Birth Weight and Maternal Mid-Arm Circumference
- 7 - Evaluation of the Effectiveness of Community-based Weighing Programs

II. Additional Studies Proposed for PHC II (Illustrative)

- 8 - Study on the Financing of the Health Care Delivery System
- 9 - Study on the Role of the Private Sector in Contributing to the PHP
- 10 - Study on the Process and Effectiveness of the Referral System with Respect to Indicator Diseases
- 11 - Study of the Costs Currently Incurred by the Health Care System in the Treatment of Septic Abortions
- 12 - Evaluation of the Information Workload of Health Care Providers from the Township down to the Village Health Post Level
- 13 - Study of the Demand in Villages for All Types of Pharmaceuticals as a Result of the Deployment of VHW's
- 14 - Studies of Ways of Increasing Involvement of VPC's or VHC's in Planning, Implementing and Evaluating the Village Health Program

4. Family Health Counseling:

a) Professional Staff Training: Top program managers in the DOH and 9 specialist hospitals and teaching centers will be updated in current knowledge and technology in reproductive health and with the program experience in other countries of the region leading to a plan of action adapted to the needs and character of Burma. Trainers will be trained in the program subject matter. In the preparatory period, 263 medical officers and sister tutors; 364 lady health visitors, nurses and midwives; and 7 auxiliary midwives will be trained. Medical officers, nurses, health assistants, lady health visitors, public health supervisors II, midwives, and auxiliary midwives posted in the additional Phase II and Phase III townships will be trained in late 1984-early 1985 and in late 1985-early 1986.

b) Establishment of Family Health Counseling Service Delivery Sites: A total of 93 hospitals, MCH centers, Social Security centers and Occupational Health centers will be equipped and supplied as Family Health Counseling Service Sites and will begin offering services in early 1984. These first-phase sites are located in 30 townships - (22 urban and 4 rural in Rangoon and 2 urban and 2 rural in Mandalay). Service sites in 40 additional townships in 1985 (Phase II) and 50 additional townships in 1986 (Phase III) will also be equipped and supplied, including divisional and township hospitals, station hospitals, rural health centers and sub-centers.

c) Management Information: Client and supply records and reporting forms will be designed and in use, as a part of the medical stores and health information systems.

d) Materials Development: Training aids and materials, service provider manuals, and information and educational materials for the general public will be produced and available to program staff.

e) Studies and Reports: Base-line survey, evaluation studies and consultant reports will be available to program administrators.

F. Project Inputs

The project inputs discussed in this section are linked directly to Project Outputs and Components presented in the previous section. Inputs include those provided by AID (dollar grant and Kyat fund), the Burmese government (DOH budget), the communities and, in some cases, other donors.

TABLE 3

PROJECT FUNDING CONTRIBUTIONS BY SOURCE

	AID Dollars	Project Fund Account (AID)	SRUB	Community	Total
By Input:					
Technical Assistance	1293 ^{1/}	0	0	0	1293
Participant Training	1434 ^{1/}	0	0	0	1434
Equipment/Supplies	6329	798		10080	17207
Building	0	494	0	0	494
Personnel	0	436	0	0	436
Studies VHW	0	123			123
Training VHW	0	2544	3095	0	5639
Training Special	0	138	0	0	138
Evaluation	200				200
Contingency	744	0	0	0	744
Total	\$10000	\$4533 ^{2/}	\$3095 ^{3/}	\$10080 ^{4/}	\$27708

^{1/} Includes Technical Assistance and Participant Training for Family Health Counseling

^{2/} Kyat 34,000,000 at K7.5 = \$1.00

^{3/} Kyat

^{4/} Kyat

25

TABLE 4

PROJECT FUNDING CONTRIBUTIONS BY COMPONENT

	AID Dollars	Project Fund Account (AID)	SRUB	Community	Total
By Component:					
VHW/Training/ Deployment	5085	2676	3095	10080	20936
Health Information Services	346	384	0	0	730
DOH Management/ Supervision	764	1138	0	0	1902
Family Health Counseling	2861	335	0	0	3196
Evaluation	200				200
Contingency	744	0	0	0	744
Total	\$10000	\$4533	\$3095	\$10080	\$27708

1. VHW Training, Supply and Deployment

The Project will provide all the inputs required to train, equip and deploy 8,200 new Community Health Workers, 2,700 Auxiliary Midwives and 12,000 Traditional Birth Attendants. In addition UNICEF will provide equipment and supplies for a further 8,200 new CHW's and AMW's.

a. AID will provide a full-time Training Advisor for two years (24 pm) and an additional 18 pm of short-term technical assistance to the DOH Training Division and HATS staff to help analyze the current improving teaching methods to be used by the S/DTTs in their training of Basic Health Services staff and by them in turn when they train VHW's. See Table Five for a listing of short-term technical assistance by component.

b. Equipment and supplies will be provided by AID in the form of kits for each VHW to take back to his/her village. The kits are standard and supplied by UNICEF to meet specific requirements of each type of worker and have been used successfully in PHC I. One modification is being made. Previously, AMW's received three kits -- Nursing Kit, Medicine Kit and Midwifery Kit. Under PHC II, the contents will be consolidated into one AMW Kit capable of serving the nursing and midwifery functions and as a medicine kit for all three functions. An initial supply of drugs and expendable supplies is included which is expected to last for approximately six - eight months. Resupply continues to be the responsibility of Village Tract People's Councils who have demonstrated that pharmaceuticals can be purchased locally.

c. Audio visual equipment, including video, will be provided to the Health Assistant Training School to increase capability to produce high quality training materials.

d. Travel and living expenses for the village volunteers to attend their pre-service training courses will be paid for from local currency in the Project Fund Account (AID).

e. The courses will be conducted by Township and Rural Health Center staff members who have been trained for that purpose by S/DTTs; usually the Township Medical Officer, a Public Health Nurse, a Lady Health Visitor and/or a Health Assistant. The salary costs for those Basic Health Services staff members are provided routinely by the DOH as part of their financial input to the Project.

f. The salary and operating costs of the 16 State and Division Training Teams will be provided from the Project Fund Account (AID). In addition, the Account will be used to pay the costs of a new S/DTT Coordinating Unit comprised of a Medical Officer, Public Health Nurse, Health Educator and a Clerk. To date there has been no staff devoted full time to planning, coordinating and supervising the performance of those teams. This new unit will be attached to HATS. Dollar funds will be used to procure a Jeep-type vehicle from the United States.

g. To strengthen the training capacity, three DOH staff members will receive long term training in the U.S. in health education and six persons will be sent abroad for short term training in health education teaching methods.

h. The Project Fund Account (AID) will finance the costs of producing training and educational materials.

i. The DOH will provide all other operating costs of the training component such as for staff salaries, materials, etc.

2. Health Information System and Research

a. AID will provide a Health Information Specialist for 12 pm plus a Computer Specialist (9 pm) and a Data Analyst (8 pm) to assist the development of the health information system (HIS) and eight pm of services of an evaluation/research methods expert to help expand and refine the DOH program of operational and evaluation research. AID will also support the training in the U.S. of several DOH professionals in biostatistics and computer science.

b. The Project Fund Account (AID) will finance various studies and surveys listed in Table 2 as part of the evaluation/research program and will pay salaries of several HIS contract employees. They will be converted to permanent service at a later date.

c. The SRUB will provide the salaries and operating costs of the staff assigned to this Project component.

3. DOH Management and Supervision

a. AID will provide training in the U.S. for DOH professional staff in maternal and child health, health administration, epidemiology and environmental sciences.

b. The Project Fund Account (AID) will be used to purchase bicycles for RHC staff to facilitate supervision of VHW's in the villages and to pay for the local costs of constructing much needed nutrition offices and a warehouse.

4. Family Healty Counseling

a. Training

AID will supply 28 person months of technical assistance to the Family Health Counseling component of the project. A Contraceptive Technology Specialist (one person month) will conduct a technical workshop for senior medical and administrative officials on the status of reproductive health knowledge and technology. The Project Fund Account (AID) will support local costs of curriculum development, training of the teaching hospital lecturers and tutors who will conduct the training, training of the senior staffs of the hospital and clinic service sites (who, in turn will train their respective staffs at no

cost to the project), and introduction of the new family health counseling services to the HATS trainers, the S/DTTs, and the DOH's Training Division and Medical Education officers. Throughout the project period AID will provide long and short-term training opportunities abroad. Grant funds are also programmed for ten person months of consultation each in training methodology and reproductive health over the life of the project.

b. Establishment of Services

Incrementally, to match the DOH's timetable for phased geographic expansion of Family Health Counseling services, AID Grant Funds and the Project Fund Account (AID) will finance basic nonexpendable clinic equipment (instruments, instrument pans, sterilizers, lamps, locally constructed examining tables) and expendable supplies (rubber gloves) to each service site; and contraceptives (oral contraceptive pills and IUDs). The clinic equipment is for both fertility regulation counseling and infertility investigation and treatment. At the central level, the Project Fund Account (AID) will fund the salaries of additional personnel needed for initiation of the new range of services but whose positions are not yet budgeted by the Government, including a medical officer to act as a deputy manager of the activity, a five-person supporting staff, and a family health counselor in each of the fourteen major hospital service locations. In addition, the project will supply typewriters, reproduction equipment and air conditioners for the national headquarters office.

A Medical Demographer (three person months) and an Information/Education Advisor (three person months) will be financed by AID from Grant Fund.

The contraceptive supply projections for the project are tentative and subject to change as the project progresses. There is no previous experience in Burma with offering services to assist couples to space their births and to avoid high-risk pregnancies. Little information is available on current use of modern contraceptive methods purchased in the open market, nor is it known how widely and consistently available such supplies are throughout the country. No one knows how many present users would switch to the Government health services as their source of supply, nor how many people will seek such services when they become accessible.

TABLE 5

Technical Assistance by Component

	<u>Type</u>	<u>PM</u>	<u>Year</u>	<u>Estimated Cost (000)</u>
I VHW Training/ deployment	A. <u>Long Term</u>			
	1. Training advisor (full-time)	24	1983/84	\$ 345
	B. <u>Short Term</u>			
	1. A/V and Video Trainer	6	1984	97
	2. Educational Methods Specialist	12	1983/84/85	194
II Health Informa- tion Service	A. <u>Short Term</u>			
	1. Health Information Specialist	12	1983/84/85	70
	2. Evaluation Research Specialist	8	1983/84	45
	3. Computer Specialist	9	1983/84/85	52
	4. Data Analyst	8	1983/84/85	46
IV Family Health Counseling	A. <u>Short Term</u>			
	1. Contraceptive Technology Specialist	1	1983	14
	2. Service Data Records Specialist	1	1983	14
	3. Training Specialist	10	1983/84/85	161
	4. Specialist in Family Counseling Service Programs	10	1983/84/85	161
	5. Medical Demographer	3	1983 or 84	49
	6. Information/Education Specialist	3	1983	49
	Total	107		\$1297

III. Project Analyses

A. Technical Analysis

The concept of Primary Health Care is established in Burma. The deployment of Volunteer Health Workers and the underlying structure of Basic Health Services will continue to expand even in the absence of AID support. There is the potential, however, for strengthening the program and accelerating attainment of the SRUB goals for providing preventive and curative health care in rural areas thereby reducing morbidity and mortality among the target population. What follows in this section is a technical analysis of those components which AID proposes to assist.

The PHC I Mid-term Evaluation and PHC II project design process confirmed that : (1) the AID contribution supports an existing network of appropriate primary health care services; (2) the absorptive capacity of the Burmese system is sufficient to utilize additional Project inputs effectively; (3) all substantive areas in which AID will be providing assistance are priorities in the Second People's Health Programme (1983-86); and, (4) the Department of Health endorses the proposed project methodologies.

Three factors enhance and assure the technical feasibility of implementing the project. First, there is a strong Burmese commitment to provide health services to the rural populace coupled with evidence that communities themselves make a substantial contribution. Second, the project involves expenditures which, although partially recurring, can be absorbed by the Burmese themselves. For example, pharmaceutical resupply for village health workers is paid for by community contributions. Third, the level of technology proposed by AID is commensurate with the nature and prevalence of disease, and is directed toward the most common and deleterious health problems in rural Burma.

The technical feasibility of the proposed project has been confirmed after careful analysis of the following areas: VHW training and deployment, health information system and evaluation/research, DOH management and supervision and Family Health Counseling. Each is discussed below.

1. Volunteer Health Worker Training and Deployment

a. Training

The heart of the volunteer health worker training in PHC I was the newly conceived State/Division Training Teams. Their prime duty was the training of BHS staff at township and village tract levels to become trainers who would in turn train VHWs in small numbers at health centers and station hospitals close to the point of recruitment. For a variety of reasons these teams never achieved their expected level of effectiveness. We believe there is a more favorable climate now for the development of these teams. The team personnel are now assigned; they have been taught some educational methods; they have

begun to redesign the curricula; this project will give them the transport to make them more mobile; there is a central management unit in formation; and a long-term advisor will be placed at the Health Assistants Training School.

Training emphasis for VHW's will be on learning through doing, seeing, thinking and problem identification, resolution and follow-up, and the inter-relation of disease control and preventive health activities. Special emphasis will be given to the treatment and prevention of diarrheal diseases, malnutrition, communicable diseases, environmental sanitation and reproductive health.

The experience of the past two years has shown that Auxiliary Midwives are better trained than Community Health Workers, by virtue of a longer, more practical training (6 months) and are better supervised by virtue of close contact with the sub-center midwife. The CHWs tend to be trained didactically in large groups (fifty or more) for only four weeks. Their supervision is not as close as that of the AMW. Better prepared, more active S/DTTs will prepare the BHS staff and the People's Council members as better trainers and supervisors.

Through the Project, AID/Burma will support the pre-service training and equipping of 8,200 CHW's, 2,700 AMW's, and 12,000 TBA's and refresher training for 8,200 CHW's (six days each year), and 2,600 AMW's (six days every two years). UNICEF and ADAB are also supporting VHW training.

The project will also:

-- Assist in the review of job descriptions for overlap, gaps, and lines of referral to assure that pre-service and refresher training is appropriate.

-- Assist in the development of the supervisory skills-building of Health Assistants, Public Health Supervisors, Lady Health Visitors, and Midwives.

-- Support field studies of the effect of practical-oriented training and resource materials on: (1) improved diagnostic abilities of and curative interventions made by CHW's; (2) the types, extent and outcomes of disease prevention activities; (3) the types of referrals made by VHW's to RHC's and the extent of household follow-up conducted by VHW's on those referrals; (4) the extent and types of environmental sanitation activities that are specifically directed toward reduction of diarrheal and communicable diseases, the extent and salience of prevention messages and advice that are given by VHW's during curative interventions for diarrheal and communicable diseases; and, (5) the extent to which VHW's use community members, especially mothers and VPC members, as educators/information-givers to other community members.

b. VHW Drug Resupply

The VHWs are given an initial supply of a few simple drugs in their kits. This supply is expected to last six months or longer. Resupply is the responsibility of the local People's Council. They raise their funds for drug purchases by a variety of methods ranging from patient contribution to assessment of each family in the community. The problem of resupply appears to be in the actual availability of drugs through Government channels or the open market.

The single domestic producer^{1/}, Burma Pharmaceutical Industries (BPI), does not manufacture its own raw drugs and must purchase these on the international market. Foreign exchange is scarce. BPI is also expected to show a profit and so it programs production of those items for which there is a ready domestic market before anything else. Most of BPI's production consists of patent medicines, rather than hard drugs or pharmaceuticals. The production capacity of BPI is being used at maximum. Purchase of specific drug items requires payment in advance. The DOH is strictly limited as to a supply channel for drugs to the network of Cooperative Stores. BPI products go into this system at the top. Funds used for purchase come up from the bottom. It has not yet been possible to unravel the money flows and accounting system. The DOH does not have a system to estimate accurately drug usage at any level of the system. As a last and much more expensive resort for drug purchase, there is the open market. AID/Burma sees no easy or rapid solution to drug resupply problem but one approach which is being given very serious consideration would involve the following:

-- Production - Several other donors, primarily the United Kingdom, West Germany and Japan have shown interest in assisting BPI expand its manufacturing capacity including hard drugs, and Ringers Lactate. The British have completed a feasibility study for expansion of the present BPI facility. More long-range and sizeable assistance is forthcoming. AID should not therefore use its scarce resources to assist BPI.

-- Supply system - AID and the DOH will develop a system that will estimate drug usage and forecast needs through the Health Information System. Distribution through the Cooperatives Stores is feasible, provided there is a sustained flow of supplies.

-- Finances - There is strong evidence that sufficient funds are available at the village level to buy drugs. AID will assist the DOH to develop a system that will use these funds to purchase drugs on a predicted need basis.

-- AID-financed drugs - AID/Burma must continue to provide the initial supply of drugs presently in the VHW kits. A few pharmaceutical items such as an anti-malarial, an antibiotic and oral rehydration salts are essential.

^{1/} There are no private sector pharmaceutical manufacturers in Burma.

c. Nutrition

Maternal, infant and child malnutrition is a problem in Burma but cases of severe or third degree malnutrition requiring intensive rehabilitation care are not common. Malnutrition is manifested by inadequate maternal weight gain during pregnancy, low birth weight babies, poor growth performance (especially during weaning), anemias from iron and/or folic acid deficiencies; and by susceptibility of young children (1-5) to infection and disease resulting in morbidity and mortality. A special set of circumstances occurs in the urban areas where there are working mothers and inadequate dietary supervision of the children of these mothers.

The Burmese Primary Health Care system can be strengthened to reduce malnutrition, which is characterized by multiple causes but which may be ameliorated even without addressing the primary economic determinants of effective demand and food availability. One major effort has been through introduction of weight surveillance, coupled with education of mothers to introduce a variety of solid foods during the weaning period. It is during this period that growth falters, and reluctance to wean is partly a result of cultural beliefs. AID's other major project in Burma - Maize and Oilseeds Production - is intended to improve nutrition by increasing the availability of edible oils, which is in short supply in the Burmese diet. In addition to such vital supply-side programs, further activities to reduce malnutrition will be undertaken within this Primary Health Care II Project including:

- Employment of CHW's and AMW's in the control of diarrheal disease and other infections in order to break the spiraling synergism of infection and malnutrition;

- The inclusion in CHW and AMW kits of ferrous sulfate/folate tablets in order to reduce the prevalence of anemia particularly in pregnant and lactating women.

- Promotion of improved food practices and habits through nutrition education. Specific attention should be given to addressing taboos such as withholding food from the sick child, and the failure to introduce a supplemental weaning food at four to five months of age;

- Support for a country-wide effort to monitor the growth of infants and children including the provision of scales, and weight charts and improved training of basic health and voluntary health personnel; and

- Family Health Counseling.

Finally, simple aggregation of data kept on growth charts by the village level worker, up through the administrative hierarchy of the health system, will serve as a basis for a viable nutrition surveillance system which must be simple and quick-reacting.

d. Environmental Sanitation

Environmental sanitation is a priority of the People's Health Programme (1983-86) and is considered one of the three major responsibilities of the Community Health Worker. By 1986, 27,910 CHW's are expected to provide environmental health services in the villages where they work with BHS personnel providing supervision, guidance and supplementary environmental health education. Motivating health workers for the construction and use of latrines as well as other environmental improvements has been problematic in many countries. However, the likelihood of bringing about meaningful change in environmental sanitation in Burma with AID support is positive. One reason for optimism is that the Village Tract People's Council, the Township People's Council (TPC), and members of the Basic Health Services staff all share responsibility for environmental sanitation. The entire village community is involved.

An important role in the environmental sanitation improvement effort is played by the Village People's Council throughout its Health and Environmental Sanitation Committee. After organization, and by employing new health education materials, the Environmental Sanitation Committee can mobilize the community in clean-up campaigns, drainage of mosquito-breeding surface water, the use of latrines, safe water storage (including the use of lids on water jars), and the proper storage of refuse and animal excreta.

To promote sound environmental health practices, pre-service and refresher training will emphasize actual practice rather than just demonstration/lecture. Practice will include: (1) how to organize a community to drain surface water; (2) how to build a latrine; (3) how to chlorinate water supplies; and (4) how to dispose of excreta and refuse. The CHW must be persuaded of the value of environmental sanitation in helping prevent and control disease and must become motivated to include environmental sanitation messages when working with the families of patients being treated for diarrhea and malaria.

2. Health Information System and Evaluation Research

a. Evaluation

There is a distinction between special evaluative research studies and a built-in evaluation system.

Evaluation research is designed to synthesize general principles concerning the feasibility of intervention strategy. The focus of concern is not improving the delivery of services or impact per se in the community where the data collection takes place; rather, the intent is to extract insights and knowledge which can be used to refine intervention strategy. This form of evaluation places a premium on good research design, and realistic sample survey techniques.

The Department of Health, with limited technical assistance supplied by AID under PHC I, has already carried out several evaluative research studies. Study design has been sound, data have been collected in a

timely fashion, and analysis has been performed. The findings of the studies are providing valuable information to guide policy making. It makes sense to fund the continuation and completion of the seven studies .

A number of other evaluative research studies will be carried out under PHC II. Proposed topics, along with a list of previous studies, are shown in Table 2. Such studies are technically feasible and will provide additional valuable data to be used during the implementation of PHC II.

Built-in evaluation, unlike evaluative research, is designed to collect data on a continual basis to determine impact at the local site. Built-in evaluation merges the task of program monitoring and evaluation. Data is collected routinely at all project sites. Key indicators of project operations and impact are selected. The system is predicated on analyzing the data for use by supervisors and management at all levels of the project hierarchy. Rapid feedback on performance is vital. Such a procedure represents self-evaluation, where project management not only collects, but is also integrally involved, in the analysis and use of data.

Some illustrative indicators that may be followed include:

- Proportion of children under weight surveillance
- Proportion of children gaining weight adequately
- Incidence of neonatal tetanus
- Proportion of children immunized
- Number of children treated for diarrhea-outcome
- Proportion of newborn under 2500 gm.
- Number of contraceptive acceptors
- Continuing contraceptive users by method

It may not be feasible to incorporate a built-in evaluation system in all project Townships until voluntary workers, Basic Health staff, Township, State/Division and central level personnel are trained. Volunteer Health Workers are already overburdened with data generation. Recent evaluation studies show that data collected by VHW's can be very inaccurate. Nevertheless, AID/Burma will work with the Department of Health to design and implement a built-in evaluation system approach.

b. Health Information System

In Burma, as in many countries, health statistics are not always reliable. The DOH recognizes the need for improving

reliability to provide a sound basis for management and policy making throughout the health sector. Under PHC I, AID provided assistance to the Health Information Service (HIS), including the installation of a Cromenco computer system and limited technical assistance. Further technical assistance, material support and training are needed under PHC II to develop a simplified health statistics collection and analysis capability in the Department of Health.

AID assistance to the health information system will include a Health Management Information Specialist who can identify with DOH counterparts specific information needs at all levels (Central, S/D, Townships, Basic Health, Primary Health) and a practical means of collecting such data. The relationship between information and decision-making must be clarified. The following issues must be examined:

-- What are management information needs and how do they correspond to decision-making?

-- For whom are data being collected?

-- How willing are health planners and managers to use information?

-- When and how often is information required?

-- What is the most effective way of presenting information?

-- Who should collect information?

-- What is the DOH capacity for effective information generation?

-- What measurement techniques should be employed?

-- How much information is enough?

Answers to these questions will suggest how to redesign information collection and analysis procedures.

Several geographic areas will be selected in which to field test the health information system. Attention will be given to the collection of hospital-based morbidity and mortality data, and to determining what role Voluntary Health Workers should play in generating accurate, community-based health statistics.

3. DOH Management and Supervision

a. Administrative Procedures

During the implementation of PHC I, management and supervision of volunteer health workers were hampered by four major difficulties: (1) lack of direct supervisory staff at Rural Health Centers; (2) inadequate training of Basic Health Services staff in

supervision techniques; (3) incomplete performance data or feedback, coupled with vague performance targets; and, (4) varying degrees of interest and participation by Township Medical Officers.

PHC II will improve administrative procedures in Townships in two States or Divisions with the goal of replicating successful techniques and methods throughout the system. In the two pilot Township areas, this effort will comprise:

- Training of RHC personnel in management/supervision skills;
- Improvements in the collection and analysis of management data;
- Systematizing the supervision and management of VHW's;
- Using VHW information and data to modify targets, measure achievements, evaluate VHW performance, and revise training curricula to match service needs and CHW performance capacity in targeted areas;
- Management of training to assure uniformity, coverage and adequate follow-up of trainees; and,
- Drug replenishment and/or resupply of other needed commodities, i.e., education materials, environmental sanitation hardware, nutrition surveillance supplies and oral rehydration salts.

Technical assistance will be made available and S/DTT's will provide the leadership to accomplish these tasks.

b. Referral and Support

After VHW's are trained and deployed, members of the RHC staff (Health Assistant, Public Health Supervisors I and II, Lady Health Visitor, and Midwives) make visits to supervise the VHW's and provide them with technical support. A portion of AID-supported training assistance will be directed toward improving their supervisory skills. AID also will provide limited technical assistance in health management and data management systems in order to design a more effective referral, communication and feedback system from the village, the RHC, and the Township Hospital. The types and number of referrals made by VHW's to the RHC's and hospitals merit bi-monthly review by the BHS supervisor and periodic review by the Township Medical Officer.

Improved diagnostic and drug utilization skills will enable the VHW's to predict drug replenishment needs accurately. Use of curative medications should become more appropriate and effective. Improvement in these skills can be monitored by supervisory personnel who check the VHW's register and patient log books. On-site technical consultation can be provided when VHW's appear to be mis-diagnosing and/or misusing medications. Project consultants will help the DOH to develop reference and resource materials for VHW's that will reinforce the

content and practice provided to them in training. Such materials should reduce the occurrence of missed or inaccurate diagnoses, inappropriate referrals, and ineffective treatment.

The role and responsibilities of Village Tract People's Councils in providing support and supervision to VHW's can be strengthened through improved orientation and training, particularly in environmental sanitation and drug replenishment matters. Technical assistance will be provided to develop training modules to increase or augment the guidance that Councils provide to VHW's. With AID-financed technical assistance, the DOH will design a module that provides information about drug therapies; information about drug pricing; and practice in planning and budgeting for drug replenishment.

4. Family Health Counseling

The decision to offer counseling and services in reproductive health will fill a conspicuous gap in Burma. Included in the Family Health Counseling scheme are: (a) contraceptive information and services, a preventive program which will give couples effective alternatives to unplanned and high-risk pregnancies; (b) evaluation of the causes of infertility, and when practical, treatment; and (c) research on genetic disorders and counseling on the probabilities of producing genetically defective offspring. In terms of impact on some of Burma's major health problems and on the goal of a strong, healthy, productive population, the fertility regulation component of Family Health Counseling has the potential for helping large numbers of people and affecting statistical health indicators positively.

The DOH and medical profession leaders involved in the design and execution of the program are highly qualified. Although they are somewhat inexperienced in directing programs in this new area, and they have not had consistent access to professional literature which reports the rapidly expanding knowledge and technology in reproductive health, they are capable of catching up to current international levels of management expertise quickly. PHC II will provide these opportunities during the preparatory phase--through a seminar conducted by visiting experts through study of other countries' experience, and by provision of professional literature. In the recent past, 60 physicians and 12 nurses have been trained under the auspices of the Johns Hopkins Program for International Education in Gynecology and Obstetrics (JHPIEGO) in endoscopic surgical techniques which can be employed in fertility investigations and other diagnostic procedures and in the sterilization procedures which are authorized for health reasons. In addition, 12 physicians have attended the JHPIEGO courses in Administration, Reproductive Health, Academic Skills for Medical School Faculty and Infertility Management.

AID is fully supportive of DOH's intention to ensure high quality family health counseling services, from the beginning. For this reason, the clinic service sites in the first phase are limited in

number and are concentrated around Rangoon and Mandalay where senior medical professionals can monitor the operation of the program intensively. Similarly, the initial training of the service delivers--medical officers, nurses, lady health visitors, midwives and auxiliary midwives, will be done with particular care so that they are secure in their knowledge and skills. Delivery of information and contraceptive services by paramedical personnel is a method used around the world with success, provided that staff are well-trained and well-supervised.

For selected program areas which need strengthening, provision is made in PHC II for expert consultations. These areas include training, data management, supply and logistics, development of educational materials, program management, and knowledge and skills in the technical field. Concurrently, the project will support long-term professional staff development through advanced education and specialized training abroad.

Based on twenty years of assisting and evaluating similar programs through out the world, and on the DOH's satisfactory execution of the primary health care program AID believes that the family health counseling approach planned by the DOH is technically feasible.

B. Economic Analysis

Economic analysis of health projects is difficult to perform because calculation of economic benefits requires accurate measurement of the health impact of various project interventions. For PHC II, as in similar projects, reliable data are not yet available to provide a baseline against which to measure change in health status of the target population. A major component of the Project is to improve the DOH Health Information System to obtain better data for the future.

In view of the above, a comparison of benefits and costs will not be attempted. Improved health status and reduced mortality among the target group is socially and economically desirable. Based on evidence in the health literature, from the experience with PHC I, and from other pilot projects in Burma, we are confident that the primary health care intervention proposed in this project will reduce morbidity and mortality of young children and reproductive age women significantly.

To assess the economic viability of the Project, emphasis will be placed on the cost side of the equation, to determine if the course of action proposed is the most cost-efficient method available.

Because the People's Health Programme (1983-86), which PHC II supports, relies on the deployment of volunteer, non-governmental, village health workers to extend health services to all villagers, the initial and recurrent budgetary costs to the SRUB and to AID are kept to a minimum. The volunteer health worker outreach initiative represents a small increment on top of the substantial investment already

made in establishing the Basic Health Services network of Station Hospitals, Rural Health Centers and Sub-Centers down to the Township level. The new initiative will multiply the health impact which the BHS doctors, nurses, midwives, lady health visitors and public health supervisors can make in the outlying communities through informed VHW referrals, the higher standard of health care provided in the villages (especially obstetrical), and by preventive health messages conveyed by the VHW's.

After initial deployment, recurrent costs for which the DOH is responsible include in-service training of replacements for VHW dropouts, the costs of handling referral cases, supervision of VHWs by BHS staff and the costs of program administration by DOH headquarters. Costs borne by individual communities are modest when disaggregated, as well. AMWs and TBAs receive a modest fee for each delivery and the communities make small donations per family to replenish the CHW's expendable supplies and drugs as well as provide a stipend when they are away for training. These supply replenishment costs have been estimated at kyat 600 per CHW per year and kyat 300-400 per AMW per year.

In sum, the SRUB and local communities will be able to shoulder all recurrent costs of primary health care services once established in each Township. The financial analysis which follows substantiates this conclusion.

C. Financial Analysis

1. DOH Health Expenditures^{1/}

Annual budgets of the Department of Health suffered decreases in real terms following 1970, along with the rest of the national budget. The budgets were usually increased modestly in nominal terms but inflation eroded their real value. Since 1978 however, modest but real gains have been made. From 1978-79, when the People's Health Programme began, to 1981-82, the recurrent portion of the health budget rose by 50% from 200 million Kyat to 300 million Kyat for an average yearly gain of 15%. During that period health accounted for approximately 6% of the total central government recurrent budget each year. In contrast, the proportion of budget devoted to education declined by one percentage point each year from 14% to 11%.

The increases in the DOH total budget (recurrent and capital, but excluding the AID contributions) from 1980-81 (the first year of PHC I) to 1982-83 were substantial, 25% and 17% annually. However, much of the gain in the second period was due to an 85% rise in capital expenditures. From 1982-83 through 1985-86, the final year of the People's Health Programme and of PHC II, capital expenditures are planned to level off, whereas recurrent expenditures are projected to rise by 5%, 38% and 5% yearly. On a per capita basis the total DOH budget represents an expenditure of 9 Kyat per person in 1980-81, projected to rise steadily to 15 Kyat in 1985-86 or a 67% gain. However, since the budget figures

^{1/} Source: DOH, 1/83. See Table 8, Section V.

have not been deflated to account for inflation, the per capita gain in real terms is less. By contrast, per capita private medical care expenditures were estimated to be 25 Kyat in 1979-80.

During 1980-81 and 1983-84 (budget for year beginning April 1, 1983), "pay and allowances" accounted for approximately 46% of the recurrent budget and "goods and services" accounted for about 44%. The remainder was made up mostly by maintenance and repairs, (5%), and travel allowances (3.5%).

DOH officers acknowledge that they do not have sufficient funds available to make the kinds of program improvements they know are needed. However, they recognize that fiscal constraints are severe throughout the Government and they are trying to make the most of what they have. Salaries have risen very slightly in recent years; transport for supervision and trainers is difficult to obtain; drugs and other supplies provided through the Central Medical Stores Division are inadequate; equipment is old, in disrepair or unavailable, etc. Nevertheless, progress is being made and budgets are being increased, especially for the rural, Basic Health Services portion, or People's Health Programme, supported by PHC I and II.

2. Recurrent Costs

During the four year period 1980-81 to 1983-84, while the total DOH recurrent budget increased by only 8.7% per year, the total Basic Health Services budget (health services at township level and below) increased by 10% yearly. More importantly, budgets for the following BHS programs which are critical to the success of the People's Health Programme increased at rates well exceeding the DOH average: Rural Health Centers -- 11%, MCH Centers - 17%, Station Hospitals - 22%. A number of centrally managed programs which benefit the PHC II rural target population also had superior rates of growth: Environmental Sanitation - 26%, Healty Assistants Training School - 15%, Nutrition Service - 14% and Malaria Service - 13%. In contrast, funds allocated for the Health Information Services were increased by 4% per year and 10% for the Central Medical Stores Department. The CMSD budget actually declined by 5% over the last two years following a 35% gain the previous year.

It appears that the budget gains made by health programs directed towards rural areas have come at the expense of urban-oriented programs. For example, the major hospitals (General Hospitals, Central Women's Hospital, Division General Hospitals and Township Hospitals) all expanded their budgets by only 5% per year during that period. By contrast, Children's Hospital in Rangoon increased by 9% per year.

In conclusion, from analysis of actual and projected budgetary outlays, and despite fiscal constraints, the Government is directing increased resources towards the rural populations who have been relatively under served by health services in the past. Additional

donor support for the primary health care, Volunteer Health Worker initiative is required because of the high initial costs. The Burmese Government appears to be capable of covering recurrent costs of a primary health care program and numerous programs which support the primary health care initiative, such as HAT's, Rural Health Centers, MCH Centers, Station Hospitals, Nutrition, Malaria and Environmental Sanitation Services. A nagging problem remains in some rural Townships, however, with drug resupply. Nevertheless, the problem is often the actual availability of drugs through CMSD or the Cooperative Stores and not the availability of funds. Communities are able to supplement what is available from the Government by purchasing in the open market but at significantly higher cost.

3. Financial Administration

The Ministry of Health financial planning process begins with broad four year budget projections to coincide with the four year development plan. Projections for the current plan (1982-1986) were made in 1981. Requests for permanent staff increases were also made at that time. Subsequently, annual detailed budgets are prepared for each fiscal year which begins April 1. Early in each fiscal year, the Ministry's Finance Department asks each Township Medical Officer to submit its budget request by "program" for the next fiscal year. Those requests are reviewed in Rangoon by the Finance Department and appropriate technical divisions. After approval by the Minister of Health, the total budget package is submitted to the Ministry of Planning and Finance for approval by July. Negotiations between the two ministries may continue until October when final Cabinet approval is received. By January, the Finance Department then sends each Township a detailed budget for the next fiscal year. Supplemental budget requests to meet unforeseen requirements are not uncommon.

Funds for operating expenses for each fiscal year are made available promptly to the Township on a quarterly basis - usually one fourth of the total - except for seasonal programs such as malaria for which funds are provided as needed. Funds are deposited in the Government bank in each Township to an account in the name of the Township Medical Officer. He is responsible for managing the account and disbursing funds for DOH programs throughout the Township, including RHC staff salaries and operating costs. The Finance Department exercises routine controls over the process. Audits are performed periodically by the SRUB central audit agency, the Inspectorate General. Operating funds are available according to the approved budget for use by the Township Basic Health Services staff.

Funds for procurement of drugs and equipment are handled differently. The Townships include those items in their annual requests, but once approved, the funds for drug purchases for the entire Ministry are turned over to the Central Medical Stores Division which procures locally from Burma Pharmaceuticals Industry (BPI) or from abroad, if it can obtain

foreign exchange. In 1982 approximately Kyat 100 million was budgeted for drugs of which approximately Kyat 30 million was spent abroad and the remainder paid to BPI.

In addition to funds budgeted by the MOH for drugs and supplies, an amount of money estimated at Kyat 900 per Village Tract is raised annually by the communities through donations, to buy drugs and supplies locally. The Finance Department is trying to refine its estimate of the amount actually spent, for the People's Health Programme depends on local communities to replenish VHW's drug supplies. Indications are that a sustained adequate supply of drugs is more of a problem than the availability of funds.

D. Social Soundness Analysis

The following social soundness analysis confirms what was written for the original Primary Health Care Project Paper.

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

The utilization and provision of health care services are affected by Theravada Buddhism, the dominant religion of Burma. Burmese Buddhists believe that one's present state of health and well-being are the results of actions in previous incarnations. Health in this context includes physical, mental and emotional states of being, as well as spiritual health. This view of health status is coupled with the Buddhist concept that suffering is an inescapable and essential element of life; that there are few events which are not painful. The inescapability of disease and pain does not, however, deter the Burmese from seeking treatment to alleviate pain and other symptoms of disease.

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

The provision of health care is a meritorious act. In Buddhist cultures like Burma, an important element of reincarnation consists of merit or ku-tho earned in voluntarily providing a service to the community. However, volunteerism in the Burmese context also means independence from government payrolls rather than the absence of any remuneration. Village Tract People's Councils (VPC's) do provide some financial compensation to volunteer health workers. Although evidence is somewhat sketchy, it appears that most AMW's receive payment in cash or kind commensurate with remuneration paid to the let-the or traditional birth attendant.

The April 1982 Mid-term Evaluation of Primary Health Care I confirmed that CHW's are continuing in their work a year or more after initial training, despite the fact that they receive little or no financial remuneration. Incentives for voluntary service in Burma are reinforced by official propaganda and an effective political structure which reaches down to States/Divisions, Townships and to Village Tract People's Councils at the periphery. Status in the community is also a powerful incentive to volunteer one's services.

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

When illness occurs, the Burmese choose from available indigenous and western practitioners. Even if rural Burmese know they are suffering naturally-caused illnesses, they frequently do not consult western-style practitioners, in part due to their scarcity in rural areas. For mild disorders, and in areas without modern medical facilities, the traditional practitioner is the only source of health care.

In any case, utilization of services is focused on curative care. A complex body of traditional knowledge about the causes of ill health, coupled with Buddhist belief in the inevitability of illness and pain, continue to mitigate against modern health prevention promotion. On the other hand, demand for medicines, both traditional and western, is high.

The Burmese Community Health Care system, which emphasizes several tiers of health services that begin at the village level, emerged from two former projects (Family Health Care and Primary Health Care). The use of voluntary lay workers -- Community Health Workers and Auxiliary Midwives -- is a prominent feature of primary health care in Burma as is the responsibility and leadership being vested in village and township councils, and in Party committees, for the coverage, acceptability and support of services.

Burmese socio-religious traditions -- earning merit, village participation, village-level leadership, youth education, voluntary labor, health service, provision of health care by local traditional practitioners (let-thes, healers, herbalists, ayurvedics and others) -- together with Articles 10, 149, 151 and 254 of the Burmese Constitution, form the basis for the Community Health Care program. The adroit integration of local, cultural and political practice and philosophy is demonstrated in good working relationships at all levels of the health system and within the People's Councils and the Burma Socialist Programme Party. There is no structural gap between the health sector and political/cultural tradition despite the introduction, over the years, of western approaches to the prevention and cure of disease.

A good example of integration is the Auxiliary Midwife (AMW) who is the contemporary version of the traditional birth attendant (let-the). There appears to be little conflict between AMW's and let-thes, in part because of the advanced age of the let-the and the reduced burden on her, but also because the AMW is, like the let-the, a community person performing largely voluntary work on a part-time basis. The let-the is still the provider of post partum massage and in-home post-natal care, and is at present, the major provider of labor, delivery and post-natal services. Although the AMW is much younger than the let-the, the AMW is selected by the Village People's Council and thereby given a powerful stamp of approval. The AMW, inexperienced at the time of her selection, is trained to deliver babies and to provide aftercare (the jobs of the let-the), but also to give pre-natal care and to provide essential services for newborns, infants and children. These latter responsibilities go beyond the let-the's usual range of activities, thus providing the village with an array of maternal and child health services that were not available before. Since the AMW is supervised by a Midwife and Lady Health Visitor, their village visits further extend the availability of MCH services for village women, since health care is given during supervisory visits.

The project strategy of expanding the availability of health services through increasing the quantity of CHW's and AMW's, and improving the quality of care they offer through regular in-service training, will expand and upgrade rural health services. Promotion of these workers' activities and their recruitment by the Village People's Councils will enhance their acceptability. Further, the policy of recruiting traditional healers as CHW's will help to integrate western-based and indigenous medicine. Although let-thes can theoretically be chosen as AMW's, it is considered unlikely that more than a few will qualify due to their age and illiteracy. The AMW's will, however, be encouraged to upgrade the skills of let-thes with whom they work but will do so at a moderate pace over the next two years owing to difficulty in identifying eligible candidates who are desirous of training.

One problem that may persist during PHC II is that the orientation of health care services -- at all levels -- is still biased toward curative care. Demand for medicines is high, and village people seek services when they are ill, or at the time of birth (delivery). Research findings now demonstrate that villagers value the health volunteer in their midst -- she/he is readily available to diagnose and treat illness and give emergency care, is the source of medicaments for minor ailments, and is the vehicle for referral to hospital. A study of time utilization of VHWs has shown that the worker who devotes more time to curative work also devotes more time to preventive activities. The reasons for this have yet to be elucidated.^{1/} A more equitable balance between curative and preventive interventions has been difficult to achieve because of the perception by villagers that medicines alone are the

1/ Dr. Aung Tun Thet and Myint Thauung, Time Utilization of Volunteer Health Workers (1982) Unpublished.

path to good health. One of the aims of this project is to shift the health services toward promoting a larger proportion of preventive services.

The Role of Women In Burma's Rural Health Care System

Women constitute a large proportion of the rural health services' cadre. AMW's, Midwives, and Lady Health Visitors are the backbone of maternal and child health services. Since rural Burmese women prefer to receive health services from women, it is expected that utilization of AMW's for ante-natal, delivery, post-natal, infant and child care, nutrition and surveillance, treatment and control of diarrheal disease, will continue to increase. Mothers skilled at mothercraft are also being enlisted by CHW's and AMW's to serve as information givers, health educators, and demonstrators of effective techniques for treating and preventing infant and child diarrhea, for sound feeding practices, and for the interpretation and application of growth chart data.

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

Women are accepted into all sectors of the economy including education, law, commerce, engineering, and agriculture as well as medicine. Traditionally, however, women doctors concentrate on obstetrics, gynecology and pediatrics. Today, women make up half of all medical students, and female doctors are no longer confined to a restricted range of specialization.

There appear to be few if any women Health Assistants, Public Health Supervisors, Township Medical and Health Officers, or District Health Officers. Also, women seldom appear as members of People's Councils. It may be possible that women will increasingly filter into leadership roles as a result of the educational progress and the personnel requirements of an expanding public health system.

Project Impact and Beneficiaries

As in Primary Health Care I, this project will have a direct and positive impact on the health status of Burma's rural population. In addition, the certain consequences of Burma's current high morbidity rates such as time lost from work and financial drain on family income caused by medical expenses will be ameliorated. With the introduction of a family health counseling dimension, the project will have short and long-term demographic impact on birth fertility and mortality.

The project anticipates direct consequences for mortality in the short-run through its explicit goal of reducing infant and childhood morbidity. While efforts to decrease the mortality rate, especially among children age 0-4, may have the short-run effect of slightly elevated population growth, the longer-term effect should be a decline in the fertility rate. This decline in fertility is due in part to a tendency of parents who experience significant changes in the probability of child survival to alter their fertility behavior accordingly, although this shift usually occurs several years after the objective situation has changed. How quickly the fertility decline will occur is a function of both the speed at which the mortality decline occurs and the pace at which parental perceptions regarding infant and childhood mortality change, as well as the acceptance of contraceptive services provided by the Government.

The most direct beneficiaries of this project include:

- a. Rural people in 33,000 villages for whom health services are more accessible.
- b. Approximately 29,000 Village Health Workers whose ability to provide health services will be developed.
- c. Five million mothers, infants and children whose health and nutritional status will improve as a result of expanded on-site and referral facilities' services.
- d. 175 BHS staff whose capacity to organize, manage, deliver and evaluate training will be improved.
- e. Approximately 13,000 VHW's, previously trained under PHC I, whose knowledge and skills will be upgraded as a result of refresher training.
- f. DOH personnel whose skills and knowledge will be improved through participant training.

Conclusion

The concept of community supported volunteer primary health care service is already well rooted in Burma. Villagers participate actively in the actual conduct of the program. Thus, the project is socially feasible and will directly benefit Burma's rural population. Proposed strategies are socially sound and will be effective in helping to improve the role of traditional healers and to integrate appropriate concepts from western-based medicine into one indigenous health system already operating throughout rural Burma.

Some important social issues were identified in Primary Health Care I:
(1) the nature of the incentive system among voluntary health workers;
(2) ethnic and geographic variability of volunteer motivation and consequent re-training needs; and (3) the acceptability/effectiveness of the CHW role as community change agent vs. curative care provider. These issues will be studied by the DOH Health Information Service.

E. Administrative Analysis

1. Government Administrative Arrangements

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

The Director General (DG) of DOH has responsibility for over-all health administration and planning which includes implementation of the People's Health Programme (1983-86). A Director of Public Health oversees the Basic Health Services (BHS) and Primary Health Care (PHC) projects.

As over-all manager of the Primary Health Care II Project, the Director of Public Health, will be responsible for providing leadership and momentum in achieving project purpose and for coordination of relevant elements of the project within the People's Health Programme (1983-86).

Coordination at the intermediate and peripheral levels is the responsibility of the Division/State Health Director who oversees both the Township Medical Officer (TMO) and Township Health Officer (THO). A number of programs and health centers are within their jurisdiction. The extension of health services to the village level through the training and supply of CHW's, AMW's and Let-thes relies on this structure being in place. Both technical training and supervision of Voluntary Health Workers are the responsibility of the rural health center staff assisted by Township Health Officers and by a cadre of Division/State trainer-supervisors funded under this project. CHW's and AMW's will be supervised by Public Health Supervisors and Midwives, respectively, from the rural health center.

Recruitment of both volunteer health workers is the responsibility of the Village Tract People's Councils (VPC's) whose membership is informed of the goals of the People's Health Programme and whose cooperation is encouraged by Division/State and Township People's Councils. Contacts are regular and effective for top-down communications. The Burma Socialist Programme Party is represented at all levels throughout the country. Party leaders regularly discuss socio-economic policies and programs of the national government and bring issues to the attention of the Councils as well as to higher levels. The project will fund the production of health orientation materials for use by Council members and by other village leaders, who have been effective in

recruiting CHW's and AMW's; overseeing their daily activities; and, raising and/or managing funds for replacement of CHW medical supplies. The project will encourage the VPC's to continue mobilizing and motivating villagers for both collective and individual service. Emphasis will be on preventive health programs.

a. Imported equipment and supplies

Goods to be purchased from UNICEF are estimated at current prices provided by UNICEF multiplied by a factor of 15% for freight and insurance and by a factor of 20% for inflation over three years. Other goods carry estimated prices plus the same freight and inflation factors.

b. Technical Assistance

Long-term consultants are calculated at \$12,500 per month plus a 15% inflation factor. Short-term consultants are calculated at \$14,000 per month plus 15%.

c. Participant Training

Costs for long-term training in the United States are \$2,400 per month plus 15% for inflation and short-term training is budgeted at \$5,000 per month plus 15%.

d. Project Fund Account (AID) Budget

All travel, per diem and salary costs are calculated on the basis of expected level of activity times established SRUB rates by grade or category of staff involved. Costs of materials to be purchased or produced, construction or rentals are based on estimates provided by the DOH according to their experience.

IV. Implementation Plan

A. Project Administration

The Department of Health is responsible for overall management and implementation of the project. A.I.D./Burma will monitor project implementation and will participate fully in all project evaluations. A.I.D./Burma will also manage and administer any A.I.D./Burma direct contracts for technical or other services. The A.I.D./Burma staff includes a full-time direct hire Health Officer who will serve as A.I.D. Project Manager as well as a foreign national contract hire Commodity Management Specialist. They will be assisted on a regular basis by the A.I.D./Burma Program Officer who is a full-time member of the Project Management Team and by several A.I.D. direct hire regional advisors, including the Regional Commodity Management Officer (RCMO) stationed in Thailand, the Regional Legal Advisor (RLA) stationed in Sri Lanka, and the Area Contracting Officer (ACO) stationed in Manila, as well as by short-term expertise from A.I.D./Washington and from neighbouring Missions, if needed.

The long-term training consultant will act as Team Leader and is expected to devote approximately two-thirds of his/her time to the VHW training function and one-third time to coordinating the other short-term technical assistance assignments with the DOH and AID Project Manager. As Team Leader, he will work very closely with the A.I.D./Burma Public Health Officer to monitor the incorporation of training for the new family health counseling services into the MCH training program. Day-to-day project management will be handled by DOH personnel working in close collaboration with the AID Project Manager and the consultant Team Leader.

B. Implementation Arrangements and Procurement

1. Technical Assistance

After many months of negotiation, a compromise was reached with the Department of Health on the issue of long versus short-term technical assistance. The Burmese preference is for short-term technical assistance (one to three months) of high quality, and on a regular recurrent basis in various skill areas. Assuming consultants are competent, and just as important, if they are culturally sensitive, the Burmese will ask for them to return, again and again. Long-term technical assistance, on the other hand, is generally approved if and only when it can be demonstrated that the assistance is necessary to have a successful project, and cannot realistically be provided on a short-term basis. A.I.D./Burma believes also that long-term technical assistance is expensive. It creates an additional management and housekeeping burden on AID, USDH and Embassy staff and thus, it should be limited to the level required for a successful project; no more no less! A.I.D./Burma is confident that the mix of technical assistance described in the project's inputs section is realistic

and adequate; it takes into consideration existing DOH capabilities and Burmese Government policy on expatriate consultants, and it can be provided through a single U.S. consulting firm.

By contracting with a single U.S. consultant firm, the project should receive timely and reliable services over the life of the project. A contract with a single organization will maximize continuity of individual services, technical guidance, and backstopping and management efficiencies in procuring services. Some specialized short-term consultant services may be obtained from other sources, as appropriate. Although AID's policy preference is for project contracting to be carried out, where possible, by the host country, it may be necessary for procurement of technical assistance services in this case to be accomplished under AID direct contracts, entered into by the ACO, A.I.D./Burma, and /or SER/CM in AID/W. This will be the subject of further discussions with the DOH prior to execution of the Project Grant Agreement. In all cases, the DOH will initiate requests for specific consultant services as they are needed according to the annual implementation plans, and the DOH and A.I.D./Burma will approve the individuals proposed before contract commitments are made and/or before they are authorized to proceed to Burma.

2. Participant Training

Requirements for participant training are set forth in Section II, E, Project Inputs. Candidates will be nominated by the DOH and identification of specific courses of instruction and educational institutions will be done in consultation with the AID Project Manager and project consultants. AID/W's Office of International Training (OIT) will make training arrangements according to established procedures, upon request of A.I.D./Burma.

3. Commodities

a. Management

Responsibility for overall management and control of commodity procurements under this project will be exercised by the Department of Health and the SRUB.

A.I.D./Burma's local hire Commodity Management Specialist will assist in ensuring maximum coordination with the SRUB in project procurement, control, and distribution. Advice and assistance will also be provided, as needed, by the Regional Commodity Management Officer (RCMO) and Regional Legal Advisor (RLA).

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b. Equipment/Commodity Listing and Specifications

The equipment and commodities planned to be procured under the project's AID-financed portion are listed in Section II, E, Inputs and in more detail in Annex F. Modifications to the lists may be made, if necessary, during the course of implementation. No major modifications are anticipated, however. Detailed lists of commodities planned to be procured from UNICEF are being furnished separately to SER/COM for its review and advice on ineligible items, as explained in subparagraph d(1) below. Detailed final specifications for procurement purposes will be prepared by the DOH with assistance of AID staff and Project consultants.

The cost estimates included in the Project Paper are on the basis of CIF Rangoon and include all incidental fees as well as a 15% inflation factor. Estimates on items planned to be procured from UNICEF under the proposed Code 935 source/origin and sole source waivers (Annex J) are based on the substantially lower prices expected to be realized through UNICEF.

c. Source and Origin

The eligible source and origin for all items to be financed under the U.S. dollar grant will generally be the U.S. only. An exception is proposed for the purchase of Code 935 source/origin items from UNICEF/Copenhagen, as was done under Primary Health Care I. These purchases are treated under a separate waiver section below and in Annex J. In addition, a relatively small amount of some local costs may be financed through dollar purchases of U.S.-owned non-PL 480 origin excess local currencies, in addition to the local costs being financed out of the U.S.-owned PL 480 origin excess local currencies earmarked for such costs in the Project Fund Account. Shipping will be dollar grant funded generally on U.S. flag vessels only. Waivers to permit AID financing of Burma flag or Code 935 flag transportation of items procured from UNICEF/Copenhagen, and perhaps other items, may however be necessary.

d. Methods of Procurement

Before signing the Project Agreement, A.I.D./Burma and the SRUB will finalize the procedures to be followed in conducting all commodity procurements under the project. It is expected that the RCMO/Thailand and the RLA/Colombo will participate in the decision process.

In order to assure expeditious purchasing, and at the same time satisfy AID regulations, commodity procurement will be broken down into several segments and be carried out through several channels. While several agencies of the SRUB routinely conduct overseas procurement of commodities, the DOH does not possess adequate facilities to conduct all such Project procurement. On the other hand, while AID/W (SER/COM) handled most offshore commodity procurement for PHC I, it is believed

that timely delivery of some commodities, especially those that are planned to be procured from UNICEF, can better be assured by having their procurement under PHC II handled directly from Burma. Therefore, the following methods of procurements are planned.

1) UNICEF Procurements

It is expected that, as in PHC I, procurement of kits for AMW's, CHW's and TBA's and equipment sets for Station Hospitals, RHC's, and Sub-Centers will continue to be from UNICEF, provided that UNICEF's prices continue to be substantially less than prices offered for comparable items by US suppliers. (See Annex J)

To effect these procurements from UNICEF, the DOH with the assistance and concurrence of A.I.D./Burma, and the RCMO/Bangkok will enter into a written agreement with UNICEF and, with the additional concurrence of the A.I.D./Burma Controller, USAID/Thailand will issue PIO/Cs under that agreement directly to UNICEF/Copenhagen.

UNIPAC catalogs and other information on the UNICEF commodities needed for preparation of the PIO/Cs are and will continue to be available from (or through) the UNICEF representative in Burma. To ensure that AID's source/origin waiver criteria and AID's rules relating to procurement of pharmaceuticals are met, A.I.D./Burma will provide SER/COM with updated lists, at the time of project authorization and approval of the source/origin and sole source waivers, of the specific items of medical supplies and equipment in current UNIPAC catalogs that are planned to be procured from UNICEF. SER/COM will review the pharmaceutical list to satisfy the Agency that all the items on it meet AID's standards of safety, efficacy, quality, and cost differential for offshore procurement of pharmaceuticals, and that none have their origin in non-Code 935 countries or would involve any known infringements of existing U.S. patents, all in accordance with the provisions of Handbook 1B, Section 4C3. SER/COM will also review the other items of supplies and equipment on the list to satisfy the Agency that the cost differentials on those items also satisfy the source/origin waiver criteria and that none have their origin in non-Code 935 countries. The results of these reviews, in terms of ineligible items and the basis for their ineligibility will then be communicated to A.I.D./Burma for its use and for the use of the DOH in the preparation and approval of PIO/Cs proposed to be issued during the life of the project to UNICEF. Any revisions during the life of the project to UNIPAC catalog items that were included on the commodity lists originally reviewed and approved by SER/COM will be communicated by A.I.D./Burma to SER/COM for its review and concurrence prior to issuance and approval of further PIO/Cs for such items.

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Additionally, it is planned to include a provision in the agreement between DOH and UNICEF, and in the PIO/Cs issued to UNICEF, that will require that UNICEF assure, to the best of its ability in the filling of PIO/C orders under the project, that any items known by it at that time to have their origin in non-Code 935 countries are excluded. UNICEF will promptly advise the DOH of any items and quantities being excluded from the filled orders for this reason. All items either originally excluded from eligibility for procurement from UNICEF based on SER/COM's reviews or subsequently not shipped by UNICEF because they were identified as being of non-Code 935 origin, will be procured from U.S. suppliers on the basis of PIO/Cs transmitted for appropriate action to SER/COM, and will be shipped to Burma, where, in the case of medical kit components, they will be incorporated into the kits.

2) DPSC Procurements

As some commodities used in health projects are readily available from the U.S. Defense Procurement Services Command (DPSC) and can be acquired quickly and with cost savings from that agency, selected items may be purchased from it. Procurement of such items will be initiated on a PIO/C basis through SER/COM/CPS in AID/W which has a day-to-day working relationship with DPSC.

3) Purchases through a PSA

Commodities which do not lend themselves to purchasing either from UNICEF or from DPSC will be so identified by A.I.D./Burma and RCMO/Bangkok and will be purchased on behalf of the DOH by a U.S. procurement services agent (PSA). It is anticipated that PSA procurement will be required for training equipment, scales, and clinic equipment for Family Health Counseling.

The PSA's services will be performed under a contract entered into either with the DOH or with the ACO or A.I.D./Burma. The ACO/Manila, RCMO/Bangkok, and/or RLA/Colombo will participate, as appropriate, in the contracting process, in either event.

A scope of work for the PSA contract will be prepared by the SRUB, with the assistance of the RCMO/Bangkok, NLT 30 days after signing of the Project Agreement. In view of the nature of the commodities to be procured and the delivery problems associated with procurements for Burma, the PSA's capabilities must include extensive forwarding and transportation know-how. Evaluation of offers will be done by an evaluation committee composed of representatives of A.I.D./Burma and the SRUB.

Commodity orders will be placed by issuance to the PSA of PIO/Cs, prepared with the assistance of the RCMO/Bangkok and the concurrence of the A.I.D./Burma Controller, USAID/Thailand. Procurement by the PSA will be required to be carried out in accordance with sound commercial practices and, to the extent applicable, the provisions of HB 11, Chapter 3. PSA procurement awards will be made, to the extent practicable, with the concurrence of the SRUB.

4) Local Procurement

Local purchases will be conducted by the SRUB. Such purchases will be in accordance with the SRUB's own procurement procedures, which, for purposes of procurement financed out of the Project Fund Account, will be reviewed and approved for soundness by A.I.D./Burma with the assistance of RCMO/Bangkok.

5) Other Purchases

From time to time it will be necessary to obtain urgently needed items in Singapore. Such purchases, which normally are of relatively small value, will be made by AIDREP/Burma on the basis of PIO/C's and purchase orders cleared with the A.I.D./Burma Controller, USAID/Thailand. Where necessary, due to the fact that Singapore is a Code 935 country, or where items purchased in Singapore were imported from countries other than the United States in the form in which purchased, appropriate source/origin waivers will be processed.

e. Delivery

Delivery of imported commodities will be on the basis of CIF Rangoon. Ocean shipping on vessels of U.S. flag registry only will be required, if financed under the dollar Grant, except as may be authorized by approved waivers. U.S. flag cargo preference requirements ("50-50 shipping") will be observed with respect to all AID-financed goods, and all-risk marine insurance of not less than 120% of CIF Rangoon commodity costs will be required for all import cargoes.

The PSA will be authorized to air freight fragile or sensitive commodities where the estimated air freight costs do not exceed by more than 15% the costs of regular ocean shipping, and some shipments of medical supplies from UNICEF may also be transported by air, if necessary and justified. Air transportation financed by AID will be on U.S. flag aircraft only, to the extent U.S. flag carrier service is available.

f. Storage and Distribution

CMSD will be responsible for clearing imported commodities through customs, for inventory control and transit storage, for distribution to the Mandalay sub-depots, and to the Divisions and States, which, in turn, will supply station hospitals and RHC's. CMSD arranges for all in-country transportation of A.I.D.-financed commodities.

CMSD has limited storage capacity at its central warehouse and the Mandalay sub-depot. Distribution resources are scarce -- four CMSD trucks are supplemented by rail, boat, and an informal network of private transport and self-service by peripheral medical personnel. Caution will have to be exercised in releasing commodities to avoid distribution bottlenecks. Accordingly, efforts will be made to keep deliveries frequent and phased in conformance with training targets. A.I.D./Burma's Commodity Management Specialist will monitor deliveries, and will physically verify and report regularly on the disposition and end-use of A.I.D.-financed commodities.

g. Waivers

(1) Experience in purchasing VHW kits from UNICEF during PHC I has been successful and it is recommended that the same procurement source be used for essentially the same items in this Project. Accordingly, a source/origin waiver to change the eligibility code for the kits, and for equipment sets for Station Hospitals, Rural Health Centers, and Sub-Centers, from Code 000 (US) to Code 935 (free world), and a sole source waiver to permit procurement of those kits and sets from UNICEF, are proposed.

The justifications for these waivers, other than the favorable experience of previous procurements are: (a) the training and familiarity of the users, village volunteer health workers, with the UNICEF kits which have been used in Burma under the People's Health Programme for a number of years, a condition which is significant in assuring acceptance in rural Burma, and (b) the substantially lower costs of commodities from UNICEF in comparison with US suppliers.

The conditions under which these waivers are requested will, if approved, be incorporated either in the Project Agreement or in a Project Implementation Letter. These are: (a) that the cost the UNICEF kits and sets CIF Rangoon be no greater than two-thirds of the CIF Rangoon cost of equivalent kits or sets from the United States (i.e., that the delivered cost from the United States be at least 50% more than the delivered cost from UNICEF Denmark), and (b) that UNICEF systematically exclude any and all non-Code 935 (i.e., Communist Bloc origin) components from the kits. It is requested that approval of this project include approval of the above source/origin waiver, permitting the purchase of approximately \$2.0 million of health worker kits and health center equipment sets from Code 935 sources/origin, and from UNICEF, subject to the above conditions. Similar waivers were approved by the Administrator with respect to PHC I. Under existing Delegations of Authority, the AA/ASIA now has sufficient authority to approve the source/origin waiver. The sole source waiver, on the other hand, must be approved by the Administrator since the value of the procurement exceeds \$500,000 and host-country contracting is proposed (Handbook 1B, Section 12C4(a)).

4. Disbursement Procedures

a. Dollar Grant Funds

Disbursement of foreign exchange for commodities, PSA services, and consultant services will be made by AID directly to suppliers whenever possible, and with the concurrence of the Burmese Government counterpart office. Some payments, where appropriate, including payments for SRUB commodity procurements from UNICEF, will be made by the Office of Controller, USAID/Thailand, acting as A.I.D./Burma's Controller and in accordance with standard AID financial procedures.

b. Project Fund Account (AID)

Local currency costs of training, commodities, and services not covered by the Department of Health's regular budget contributions or by the contribution of cooperating village communities, will be financed out of funds drawn from a Project Fund Account that has already been established for this purpose. A sum of Kyat 34,000,000 ^{1/} out of the total PHC I Kyat Grant that was disbursed in January 1983 and was deposited at that time in a Project Fund Account in the Union of Burma Bank in Rangoon has been earmarked (Part C of the PHC I Kyat Grant) for use in meeting anticipated local costs of the present project (PHC II), or if mutual agreement to proceed with the present project is not reached, for other mutually agreed additional activities in the health sector of Burma that will directly contribute to achieving the goals of PHC I. The method of disbursement from the Project Fund Account and the expenditure reports required with respect to funds withdrawn from it are described in detail in Amendment No.3 to the Primary Health Care I Project Agreement and the simultaneously-signed PHC I Project Implementation Letter No.12 (Annex E).

If mutual agreement to proceed with the present project is reached, the specific activities, facilities, and costs to be financed out of funds withdrawn from the Project Fund Account are to be specified and described in the Project Grant Agreement for this project. A detailed breakout of the intended uses of the Kyat 34.0 million is contained in Annex E.

c. Department of Health Regular Budget

Procedures for disbursement of the Department of Health's regular budget funds in support of Primary Health Care are described in Section III C. para 2.

^{1/} See Table 6 for Project Fund Account (AID) summary.

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TABLE 6

PROJECT FUND ACCOUNT (AID) BUDGET

(Kyat and Dollars in Thousands @ K7.5 = \$1.00)

	<u>Kyat</u>	<u>Dollars</u>
I. VHW Deployment		
A. CHW/AMW Pre-service Training	8,583	1,144
B. CHW/AMW In-service Training	4,451	593
C. TBA Training	4,037	538
D. State/Division Training Teams	1,765	235
E. VTPC and VHC Orientation	425	57
F. Materials Production	<u>1,155</u>	<u>154</u>
Sub-total	20,416	2,721
II. Health Information System/Research		
A. Studies, Surveys, Workshops	552	73
B. HIS Personnel	<u>1,730</u>	<u>230</u>
Sub-total	2,282	305
III. DOH Management/Supervision		
A. Project Headquarters	128	17
B. BHS Staff Bicycles	4,650	620
C. Building construction		
1. Nutrition Center	3,000	400
2. Warehouse	330	44
3. Family Counseling office	500	67
D. Logistics staff	<u>54</u>	<u>7</u>
Sub-total	8,662	1,155
IV. Family Health Counseling		
A. Furniture, equipment, supplies	188	25
B. Training	1,048	140
C. Training Materials	150	20
D. Studies/Surveys	375	50
E. Salaries	<u>375</u>	<u>50</u>
Sub-total	2,136	285
V. Contingency	<u>504</u>	<u>67</u>
Total	<u>34,000</u>	<u>4,533</u>

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C. Implementation Schedule

Participant training and a commodities delivery schedule as well as suggested timing of long-term technical assistance and short-term consultant services are included in the Implementation Plan. The schedule of initial project events is:

Schedule of Actions

	<u>Date</u>
A. PP submitted to A.I.D./W and to SRUB	March 1983
B. PP approved by SRUB	April 1983
C. Project and AID Dollar Grant Authorized and waivers approved by AID/W	April 1983
D. Project Grant Agreement negotiated and signed	April-May 1983
E. Initial CP's met and DOH/UNICEF Agreement signed	June 1983
F. Scopes of Work for long-term and short-term TA Services completed, and notice requesting expression of interest published in Commerce Business Daily	June 1983
G. Detailed Commodity procurement specifications completed	June 1983
H. Proposals solicited from potential procurement services agents	June-July 1983
I. Initial PIO/C's issued to UNICEF	June-July 1983
J. Request for Proposals for TA services issued	July 1983
K. PSA contract negotiated and signed	August 1983
L. Initial PIO/C's issued to PSA	August-September 1983
M. Proposals for TA Services evaluated	September-October 1983
N. Contract for TA Services negotiated and signed	November-December 1983

Actual project implementation can begin by May 1983, which is early in the SRUB's Fiscal Year 1983/84. Activities can be underway by the summer of 1983. The first annual project review can be done in the Summer or Fall of 1984. A mid-term evaluation should be conducted in the Fall of 1985.

D. Evaluation Arrangements

The Department of Health coordinates project evaluations annually in which AID and other donors are invited to participate. The first evaluations of the Primary Health Care Project should occur one year after signing the Project Agreement. AID will sponsor a Mid-term Evaluation which will focus on project implementation and an End-of-project Evaluation which will focus attempt to assess project impact and success by looking at the following:

1. - Number of regular weight surveillance clinics
 - Proportion of children under surveillance
 - Proportion of children gaining weight adequately
2. - Number and types of patients at family health counseling clinics
 - Acceptors by method
 - Continuation by method
 - Infertility clinic attendance
 - Hospital admissions for septic abortion
3. - Incidence of diarrheal disease
 - Numbers treated with ORS
 - Numbers referred to RHC or hospital with diarrhea
4. - Progress in curriculum redesign and content as well as teaching method revision
5. - The progress toward functional S/DDTs and their ability to train BHS workers at the RHC and township level.
6. - The latest findings of the (7) evaluation studies begun during PHC I.

The ability to provide this information will be the test of the project's efforts to improve the Department of Health's Health Information Service data gathering, reporting and analysis capability.

V. Cost Estimates and Financial Plan

A. Project Cost

The total cost of the Project is estimated to be the equivalent of \$50,334,000. That amount includes dollar grant funds provided by AID, the Project Fund Account (AID), the SRUB Department of Health's regular budget contribution, the contributions of the rural communities which can be directly attributed to the Project and the inputs of UNICEF, WHO and Australian Development Aid Bureau (ADAB) who are providing substantial financial and technical support for primary health care in parallel financing to this project. The DOH and communities also contribute a much larger amount in terms of budget, time, energy and materials which cannot be estimated with accuracy. (See Table 7).

AID will contribute \$10.0 million over three fiscal years for foreign exchange costs of the Project and Kyat 34.0 million from the Project Fund Account (AID) to augment the Government's regular budget contribution. AID's FY 1983 dollar grant contribution is expected to be \$5.1 million. Table 6 provides a breakout of how the Project Fund Account (AID) funds are expected to be used. Further detail is provided in Annex D regarding the cost of specific activities. The basis upon which cost estimates were made is explained along side each item.

B. Other Donor Assistance to Primary Health Care

AUSTRALIAN DEVELOPMENT ASSISTANCE BUREAU (ADAB)

The ADAB will continue to carry out an extensive village water supply project in the "dry" zone of Upper Burma (Magwe, Mandalay, Sagaing Divisions). Each installation includes a deep well, a pump, and a storage tank with multiple taps providing villages with their first convenient, consistent water supply.

ADAB and the Department of Health are also negotiating possible Australian assistance to primary health care expansion to the three "dry" zone Division. This will relieve AID and UNICEF of some demands.

U N I C E F

UNICEF assistance to Primary Health Care includes supplies, training and equipment for one-half of the CHWs and AMWs deployed. In addition, UNICEF supports a village water supply project; latrine construction; assistance to Burma Pharmaceutical Industries (the source of health worker re-supply); nutrition surveillance and rehabilitation; and vaccines for the Expanded Program of Immunization. All of these activities have a direct bearing upon Primary Health Care.

W H O

WHO supports Primary Health Care through a variety of in-country training workshops and seminars, fellowships and short-term consultants. WHO acts as a conduit for other donor funds for specific health programs (e.g. - the Netherlands contribution to the malaria program).

TABLE 7

SUMMARY OF PRIMARY HEALTH CARE CONTRIBUTIONS (\$000's)

	Year 1 ^{1/}	Year 2 ^{1/}	Year 3 ^{1/}	Year 4 ^{1/}	Total	%
	\$	\$	\$	\$	\$	
Burmese Contribution						
- Government	456	760	874	1,005	3,095	7
- Community	2,520	2,520	2,520	2,520	10,080	20
AID						
- US\$	5,100	3,000	1,900		10,000	20
- Project Fund Account (AID)	2,266	1,133	1,133		4,533	9
Australian						
- A\$	1,729	2,068	2,129	N/A	5,926	12
- Local Currency	681	681	681	N/A	2,043	4
WHO	580	590	610	620	2,400	4
UNICEF ^{2/}	<u>2,486</u>	<u>2,816</u>	<u>3,287</u>	<u>3,669</u>	<u>12,257</u>	<u>24</u>
Total	15,818	13,568	13,134	7,814	50,334	100.0

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^{1/} The four year schedule corresponds to the 1983/1986 SRUB Four-Year Plan. USAID is supporting the first three years only.

^{2/} Includes contribution for Primary Health Care workers and Basic Health Services, as well as Development of Health Logistic, Latrine Construction, EPI and Trachoma Control.

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C. DOH Counterpart Contribution

The DOH does not have an amount of money specifically earmarked for primary health care as counterpart for this project. However, the budget for Basic Health Services ^{1/} (Township and below) is clearly identified in the DOH budget and is essentially devoted to the People's Health Programme, of which PHC I and PHC II comprise the major component. Based on budget information provided by the DOH, a modest but specific contribution of \$3,095,000 from the DOH regular budget was calculated as the counterpart contribution. From 1982/83 to 1983/84 the DOH recurrent budget grew by 9% or by Kyat 17.1 million, to a total of Kyat 114.0 million. Budget growth is further projected at 15% compounded through 1986/87, reaching a total of Kyat 226.1 million in the last year of the project. One third of the actual and projected recurrent budget growth earmarked for Basic Health Services was captured, and conservatively attributed as extra budgetary requirements stemming from PHC II; for a total DOH contribution of \$3,095,000. This amount does not include sums provided to the Central Medical Stores Department for pharmaceuticals supplied to rural areas nor salaries of DOH State/Division or headquarters staff.

D. Community Contribution

The community contributions collected by the Village Tract People's Councils to purchase pharmaceuticals and other expendable supplies for the CHW's in their villages, were based on an estimate of an average 21,000 CHW's working during the project period, times four years, times Kyat 900 per year. The total of Kyat 75.6 million is equivalent to \$10,080,000 at \$1 equals Kyat 7.5.

^{1/} Basic Health Services includes Health Information Service, nutrition and MCH Services, environmental sanitation, malaria eradication, the Health Assistants Training and rural Nurses Training Schools, Township and Station Hospitals, and rural health centers.

TABLE 8
 MINISTRY OF HEALTH BUDGET
 1980-1984 (Kyat 000)

Selected Line Items ^{1/}	1980/81 Actual	1981/82 Actual	1982/83 Revised Estimate	1983/84 Budget Estimate
1. Recurrent Costs	250036	316537	325028	317803
2. Capital Costs	41141	65847	121757	77000
3. Selected Line Items ^{1/}				
Health Information Service	518	551	539	576
Nutrition	192	252	275	284
Environmental Sanitation	329	328	538	611
Malaria	4806	5518	6332	6514
Health Assistant Training School	448	479	639	670
Nurses Training School	2065	2307	2424	2549
Township Hospitals	37211	43511	43308	43724
Station Hospitals	4318	5643	7009	7826
Rural Health Centers	33147	39727	42849	44737
Maternal & Child Health Centers	3917	4995	5686	6227

^{1/} These line items were selected because these activities contribute directly to Primary Health Care II.

6.1

VI. Conditions Precedent, Covenants, Status of Negotiations, Waivers

A. Conditions Precedent

1. To initial disbursement - designation of representatives.
2. To disbursement for paper and printing supplies - a plan for ensuring that facilities will be available, or made available, on a timely basis for the proper storage of such supplies.
3. To disbursement for medical supplies and equipment - a plan for ensuring that imported project commodities are cleared through customs in timely fashion and are thereafter distributed in timely fashion to station hospitals, rural health centers, sub-centers, family health counseling clinics, and voluntary health workers; and an agreement between the SRUB and UNICEF for the supply by UNICEF of medical supplies and equipment.

B. Covenants

1. Assurance that all commodities financed under the project will be properly stored and that an in-country transportation system is in place to facilitate timely delivery of commodities at all levels.
2. Assurance of adequate budgetary and staff support for the project.
3. Agreement to permit technical advisors provided under the project to enter and leave the country unhindered and free of charge at any time; agreement to enter appropriate multiple-entry visas in their passports without delay and to issue to them without delay or charge any requisite work, residence, or other permits.

C. Negotiating Status

The Primary Health Care II project has been under discussion with the Department of Health, Ministry of Health, since March, 1982. The project is based upon the results of the Mid-term Evaluation of the original project, the objectives of the Second People's Health Programme (1983-86), discussions with DOH personnel, and field observations.

Based on collaborative discussions between the Department of Health and AID, many improvements and refinements have been made in project design. The PP reflects an agreement between AID/Burma and the Department of Health on project concept, design and components, sharing of costs, priorities, and covenants. Project details have also been reviewed and coordinated with WHO and UNICEF and have taken into account their respective contributions.

The project has not, however, been negotiated with the Ministry of Planning and Finance (MOPF), AID/Burma's principal counterpart Ministry, nor has it been submitted to the Cabinet. MOPF is aware, in general terms

of the project. In addition, MOPF was immediately involved in negotiating the PL 480-origin Kyat Grant Agreement under which Kyat 34,000,000 out of the total Kyat Grant that was deposited in the Project Fund Account was earmarked for use in financing local costs of this project. Copies of the PP are being provided to both MOH and MOPF for advance review and study while AID/W reviews of the PP proceed.

Following project authorization, negotiations of the Project Grant Agreement with the Ministry of Planning and Finance and MOH will proceed.. This will include formal agreement on the specific uses of the Kyat 34,000,000 portion of the Kyat Grant and the SRUB budgetary contribution to the project, as well as of the Dollar Grant, the terms and conditions of the Project Agreement, and any other SRUB undertakings in connection with the project. Only after all negotiations with the Ministry of Planning and Finance and the Ministry of Health are completed do we expect the SRUB to present the entire agreed project to the Burmese Cabinet for final review and approval.

D. Waivers

Voluntary Health Worker kits will be purchased from UNICEF in Copenhagen for the following reasons:

1. Compatibility of supplies and training. As this project is an add-on to PHC I and to an earlier one being assisted by UNICEF, compatibility of commodities is important to achieve standardization. VHWs are trained, and the training of VHWs is geared to teaching them, to dispense UNICEF-supplied drugs. Further, the CMSD has procedures and personnel in place for receiving, handling and distributing UNICEF kits.

2. Cost Savings. Due to UNICEF's large volume and system of competitive bidding, UNICEF can supply most of the necessary medical supplies and kits at one-half or less of U.S. prices.

For these reasons, source/origin and sole source waivers are proposed for all items contemplated for UNICEF (Code 935) procurement. Source and origin of UNICEF supplies vary by lot. In the event that any of the regular UNICEF items are of non-935 source/origin, they will be excluded from the procurement, and items of 000 source/origin will be procured from U.S. suppliers and substituted. With the exception of the specific 935 source/origin procurement through UNICEF, the authorized source and origin for all other Dollar Grant financed commodity procurement is Code 000.

Primary Health Care II Project Paper

ANNEXES

- A. Logical Framework Matrix
- B. Project Identification Document (PID) Approval Cable and Discussion of Issues
- C. Project Background Data
- D. Project Funding Tables
- E. Project Fund Account (A.I.D.)
- F. Project Commodity Lists
- G. Implementation Plan Bar Chart
- H. Country Checklist/Statutory Checklist
- I. Project Authorization and Amendment
- J. Source/Origin and Transportation Waivers and Justification for Non-Competitive Procurement
- K. Burmese Government Request for Assistance
- L. Annex L - Documents Reviewed in PP Preparation

LOGICAL FRAMEWORK MATRIX

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PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

(INSTRUCTION: THIS IS AN OPTIONAL FORM WHICH CAN BE USED AS AN AID TO ORGANIZING DATA FOR THE PAR REPORT. IT NEED NOT BE RETAINED OR SUBMITTED.)

Life of Project:
From FY 83 to FY 85
Total U.S. Funding \$10.0 million
Date Prepared: 2/20/83

Project Title & Number: PRIMARY HEALTH CARE II (482-0004)

PAGE 1

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p>Program or Sector Goal: The broader objective to which this project contributes: (A-1)</p> <p>Institute declining morbidity and mortality among children under 5 and their mothers that is caused by</p> <ul style="list-style-type: none"> - diarrheal disease - malnutrition - selected infectious disease - improper obstetrical care - unregulated fertility 	<p>Measures of Goal Achievement: (A-2)</p> <p><u>Morbidity</u> 1983 % Change Diarrhea #/1000</p> <p>Malnutrition normal wt/age #/1000</p> <p>Neonatal tetanus #/1000</p> <p># Newborn entering surveillance system</p> <p># Hospital Admissions for Abortion</p> <p><u>Mortality</u></p> <p>Diarrheal dis #/1000</p> <p>Neonatal tetanus #/1000</p> <p>Maternal #/1000</p>	<p>(A-3)</p> <ul style="list-style-type: none"> - Records of AMW/MW weight clinics - Sample surveys - Hospital admission records - AMW/MW logs 	<p>Assumptions for achieving goal targets: (A-4)</p> <ul style="list-style-type: none"> - Data collection is extensive, accurate and timely enough to measure morbidity and mortality decline. - Volunteer Health Workers are supported and supplied by Village People's Council. - The curative care health chain is strong enough to accept and care for referrals from VHW's.

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PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

Life of Project: _____
From FY 83 to FY 85
Total U.S. Funding \$10.0 million
Date Prepared: 2/20/83

Project Title & Number: Primary Health Care II (482-0004)

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p>Project Purpose: (B-1)</p> <p>a. To expand rural health services coverage in Burma by Volunteer health Workers, with increased emphasis on quality of services thru improved pre-service and in-service training.</p> <p>b. To introduce fertility and infertility counselling and services as an integral part of MCH services.</p>	<p>Conditions that will indicate purpose has been achieved: End of project status. (B-2)</p> <p><u>End-of-Project Status Coverage</u> An additional</p> <ul style="list-style-type: none"> - 8000 CHW's trained, equipped and deployed to rural areas in (147) townships - 2701 AMW's trained, equipped and deployed - 12500 TBA's trained, equipped and deployed <p>Throughout Burma:</p> <ul style="list-style-type: none"> - 45% of villages will have a CHW - 100% of Village Tracts will have an AMW or MW - 15,000 trained TBA - 120 of 314 rural and urban townships offer reproductive health services - Approx. 15% of Eligible Couples using contraceptive services provided by the DOH Public Health Program in areas offered and infertility services available in 15 locations by 1986. 	<p>(B-3)</p> <ul style="list-style-type: none"> -DOH records of pre-service and in-service training by location. -AMW/CHW logs -HIS aggregation of AMW/Chw logs -Sample surveys -Hospital and clinic MCH records 	<p>Assumptions for achieving purpose:</p> <ul style="list-style-type: none"> -Task oriented, practical training will raise level of worker competence and hence quality of service. -Villages will recognize and utilize competent medical assistance. -There is a demand for Family Health Counselling services.

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PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

Life of Project: From FY 83 to FY 85
Total U.S. Funding \$10.0 million
Date Prepared: 2/20/83

Project Title & Number: PRIMARY HEALTH CARE II (482-0004)

PAGE 3

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p>Project Purpose: (B-1)</p>	<p>Conditions that will indicate purpose has been achieved: End-of-Project status. (B-2)</p> <p><u>CHW</u></p> <p>An increase in the number # Latrines in villages</p> <p>Village sanitation check list to insure</p> <ul style="list-style-type: none"> - no scattered refuse - no standing water - covered water containers in use <p>An increase in the amount of Personal hygiene</p> <ul style="list-style-type: none"> - lectures with increased attendance <p>Immunizations arranged by VHW</p> <p>Curative treatments</p> <ul style="list-style-type: none"> # diarrhea cases # first aid patients # total patients <p>An improvement in VHW Diagnostic skills</p>	<p>(B-3)</p> <p>Site visits</p> <p>HIS Reports</p> <p>Annual DOH Evaluations</p> <p>Inspection of CHW logs</p> <p>USAID Evaluation</p> <p>Corroborating diagnoses from RIC or Township Medical staff</p>	<p>Assumptions for achieving purpose: (B-4)</p> <ol style="list-style-type: none"> 1. That job oriented training of volunteers with regular in-service training and supervision will be sufficient to enable workers to influence villagers. 2. That the VTPC councils can and will provide support to the volunteer workers to institute changed behavior.

PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

Life of Project:
From FY 83 to FY 85
Total U.S. Funding \$10.0 million
Date Prepared: 2/20/83

Project Title & Number: Primary Health Care II (482-0004)

Page 4

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
Project Purpose: (B-1)	Conditions that will indicate purpose has been achieved: End of project status. (B-2)	(B-3)	Assumptions for achieving purpose:

Quality
AMH

Obstetrical care at the Village level including increase in the urban of

- Prenatal visits
- Deliveries
- Post-natal visits

A Nutrition surveillance system in place which tabulates numbers

- # regularly weighed
- # newborn in regular weighing
- # not gaining % decrease
- # < 5 diarrhea % decrease

PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

From FY 83 to FY 85
Total U.S. Funding \$10.0 million
Date Prepared: 2/20/83

Project Number: Primary Health Care II (482-0004)

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS												
(C-1)	Magnitude of Outputs: (C-2)	(C-3)	Assumptions for achieving outputs: (C-4)												
<u>Training System Improvement</u>	<u>Training</u>														
Curricula revised for more practical, task-oriented training (pre and in-service).	- New 4 week CHW course	- Review of printed curricula, workers and trainers manuals	- S/DTT's will be recruited by the Department of Health and after training will be encouraged to perform training and supervisory duties.												
Training methods and teaching aids geared to practical, task-oriented training.	- Additional material on R. of diarrheal disease and weight surveillance	- Field checks													
S/DTTs appointed, working and using revised curricula which contain basic principles of management.	- In-service training on annual basis (5 days)	- Records of pre and in-service courses	- DOH will coordinate with the Burundian Socialist Program Party, the Ministry of Home and Religious Affairs and village-based organization like the Youth Corps in arranging conducting Village People's Council orientation courses.												
Implementation of VTPC & TPC complete in 147 Townships	- Trainers manuals - 1984														
In-service training of CHW, AMW, TBA complete in 147 Townships	- VHW workers manuals - 1984														
In-service training of CHW, AMW, TBA complete in 147 Townships	- Community education materials developed - 1984														
In-service training of CHW, AMW, TBA complete in 147 Townships	- S/DTTs recruited and trained in 14 State and Divisions														
	- % of townships with all VPCs oriented														
	- Number of VHW's trained:														
	<table border="1"> <thead> <tr> <th></th> <th>Pre-Service</th> <th>In-Service</th> </tr> </thead> <tbody> <tr> <td>CHW</td> <td>8000</td> <td>22158</td> </tr> <tr> <td>AMW</td> <td>2801</td> <td>7200</td> </tr> <tr> <td>TBA</td> <td>12000</td> <td></td> </tr> </tbody> </table>		Pre-Service	In-Service	CHW	8000	22158	AMW	2801	7200	TBA	12000			
	Pre-Service	In-Service													
CHW	8000	22158													
AMW	2801	7200													
TBA	12000														

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PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

10-10-79

Title & Number: Primary Health Care II (482-0004)

From PI _____
Total U.S. Funding: \$10.0 million
Date Prepared: 2/20/83

Page 6

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
(C-1)	Magnitude of Outputs: (C-2)	(C-3)	Assumptions for achieving outputs: (C-4)
<p><u>B. Production and Distribution System</u></p> <ul style="list-style-type: none"> - VHW initial supply kits issued each AMW, VHW, TBA - VHW resupply system in place 	<ul style="list-style-type: none"> - <u>Number of Kits Issued:</u> <ul style="list-style-type: none"> 7 8000 CHW kits 2801 AMW 12000 TBA - All workers get essential resupply from BPI or open market. 	<ul style="list-style-type: none"> - Record of distribution - Field checks - Field checks - Records of distribution Field checks 	<ul style="list-style-type: none"> - AID able to deliver commodities on schedule. - BPI produces needed drugs; VTPC provide funds; supply system operates to provide supplies. - DOH develops inventory system.
<p><u>Health Information System</u></p> <p>MIS Reporting System in operation and reports in hands of health planners/managers</p>	<p>Reports covering at a minimum these items by Township:</p> <ol style="list-style-type: none"> 1. # of <5 children with diarrhea 2. # of <5 deaths due to diarrhea 3. # of newborn entering weight surveillance 4. # Proportion of children <5 below standard of wt/age. 5. # of pregnant women under observation. 6. # of deaths due to childbirth 7. # of cases of neonatal tetanus admitted to hospital 	<p>Published Reports</p>	<p>Decision on data to be collected 1983.</p> <p>Collection procedures established 1984.</p> <p>Analysis procedures by 1984.</p> <p>Publication by 1984</p>

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PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

Life of Project:
From FY 83 to FY 85
Total U.S. Funding \$10.0 million
Date Prepared: 2/20/83
Page 7

Title & Number: Primary Health Care II (482-0004)

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p>Code: (C-1)</p> <p>1. Family Health Counselling Service Sites in Operation staffed by trained persons and equipped and supplied</p> <p>Forms designed and adopted:</p> <ul style="list-style-type: none"> - Client records - Supply system records - Reporting <p>Studies and reports available to administrators</p>	<p>Magnitude of Outputs: (C-2)</p> <ul style="list-style-type: none"> - Approx. 600 clinical service sites in 120 townships: 1984-93 1985-40 1986-50 - Every clinical site and domiciliary service provider - Base-line measures of fertility-related morbidity and mortality among women; infants and children; and of contraceptive use - Reports of findings and recommendations by consultants 	<p>(C-3)</p> <ul style="list-style-type: none"> Service statistics Site visits Monthly service statistical reports Monthly supply issuance, stock balance, and distribution reports Site visits Published reports 	<p>Assumptions for achieving outputs: (C-4)</p> <ul style="list-style-type: none"> Timely procurement, arrival and distribution of clinical equipment and contraceptives. Willingness of administrators and MOH technical staff to accept revised or additional recording and reporting forms. Availability of sufficient data to establish base-line indicators

PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

Life of Project: _____
From FY 83 to FY 85
Total U.S. Funding \$10.0 million
Date Prepared: 2/1984

Project Title & Number: PRIMARY HEALTH CARE II (482-0004)

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS		MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
Project Inputs: (D-1)	Implementation Target (Type and Quantity) (D-2)		(D-3)	Assumptions for providing inputs: (D-4)
	1/ FX (\$000)	2/ LC (K000)		
A. VHW Training/Deployment			Grant Agreement	1. Other Donor Support (WHO, UNICEF, ADAB forthcoming as described in Table 5).
1. Technical Assistance (42 pm)		42 pm 636 636	PILs and PIOs	
2. Commodities			Mid-term Evaluation	2. Single host-country contract with U.S. consulting firm can provide bulk of T.A. Services.
(CHW kits)		8200 ea. 840 -	DOH Health Information System reports	3. A pool of participant training candidates exists sufficient to select adequate number of participants with technical skills and English language capability.
(AMW kits)		2800 ea. 139 -		
(AMW Medicine kit)		5600 ea. 611 -		
(TBA kits)		12000 ea. 288 -		
(AMW kit cases)		5600 ea. 54 -		
(Scales)		6000 ea. 180 -		
(Drugs - initial supply)		- 676 -		
(RHC equip.)		280 RHC's 103 -		
(Sub-center equip.)		1120 Sub-center 56 -		
(Station hospital equip.)		40 hospital 600 -		
(Training equip./A-V/Video)		- 250 -		
(Vehicles - S/DTT/F.H.C.)		22 330 -		
		4127 -		

1/ AID dollar grant

2/ Project Fund Account (AID)

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PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

Life of Project: _____
From FY 83 to FY 85
Total U.S. Funding \$10.0 million
Date Prepared: 2/20/83

Project Title & Number: PRIMARY HEALTH CARE II (482-0004)

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS		MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
Project Inputs: (D-1)	Implementation Target (Type and Quantity) (D-2)		(D-3)	Assumptions for providing inputs: (D-4)
	FX (\$000)	LC (K000)		
3. Participant Training				
(MPH) (Health Ed.)	1 ea.	50	-	
(MPH) (Health Ed.) (Nurse)	1 ea.	67	-	
(M.Sc.) Educ. Science (Nurse)	1 ea.	67	-	
(Educ. Techniques)				
(2/yr X 3 yr X 4 mo.)	24 pm	138	-	
		322	-	
4. (CHW/AMW Preservice Training)	22000	-	8583	
(CHW/AMW In-service Training)	96000	-	4451	
(TBA Training)	12000	-	4037	
(S/D Training Teams)	15 teams	-	1765	
(VTPC and VHC Orientation)	2700 counselors	-	425	
(Materials Production)	-	1155		
		-	20416	
B. Health Information Service				
1. Technical Assistance	37 pm	211	-	
2. Participant Training (MPH Bio Statistics)				
(M.Sc. Computer Science)	1 ea.	50	-	
(MPH Health Statistics/ Demography)	1 ea.	50	-	
(MPH Health Statistics/ Demography)	1 ea.	35	-	
3. Studies, Surveys, and Workshops				
HIS Personnel	26	-	1730	
		346	2282	

PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

Life of Project: _____
From FY 83 to FY 85
Total U.S. Funding \$10.0 million
Date Prepared: 2/26/83

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Project Title & Number: PRIMARY HEALTH CARE II (482-0004)

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS		MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
Project Inputs: (D-1)	Implementation Target (Type and Quantity) (D-2)		(D-3)	Assumptions for providing inputs: (D-4)
	FX (\$000)	LC (K000)		
C. DOH Management/Supervision				
1. Participant Training				
(PhD.-Health Admin.)	1 ea.	99	-	
(MPH - Health Admin.)	1 ea.	50	-	
(MPH - Three - MCH)	13 ea.	150	-	
(PhD.-Epidemiology)	1 ea.	99	-	
(MPH-Epidemiology)	1 ea.	50	-	
(M.Sc.-Environmental Science)	1 ea.	50	-	
Short-term				
(MCH)	24 mos.	138	-	
(Health Planning/Management)	18 mos.	105	-	
(Environmental Health)	4 mos.	23	-	
		764	-	
2. (Project Headquarters staff)	3 persons	-	128	
(BHS Staff bicycles)	4650 ea.	-	4650	
(Building construction)				
(Nutrition)	1 ea.	-	3000	
(Warehouse)	1 ea.	-	330	
(Family Health Counseling)	1 ea.	-	500	
(Logistics Staff)	3 persons	-	54	
		8662		

PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

Life of Project: _____
From FY 83 to FY 85
Total U.S. Funding \$10.0 million
Date Prepared: 2/20/83

21

Project Title & Number: PRIMARY HEALTH CARE II (482-0004)

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS			MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
Project inputs: (D-1)	Implementation Target (Type and Quantity) (D-2)			(D-3)	Assumptions for providing inputs: (D-4)
	FX (\$000)	LC (K000)			
D. Family Health Counseling					
1. Technical Assistance					
	-28 pm	446	-		
2. Commodities					
(Paper, ink, stationery)	-	200	-		
(Clinic equip.)	225 ea.	450	-		
(Contraceptives)	r	1300	-		
(Medical kits)	225 ea.	117	-		
(IUD)	-	100	-		
(Office equipment)	1 set	130	-		
(Library books)	1 set	5	-		
		2202	-		
3. Participant Training					
(Observation tours)	12 pm	30	-		
(Management Training)	6 pm	30	-		
(MPH - Family Health Counseling)	2 ea.	100	-		
(Training of Trainers) (Unspecified Short-term)	4 pm	23	-		
	-	30	-		
		213	-		

PROJECT DESIGN SUMMARY
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NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS		MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS										
Project Inputs: (D-1)	Implementation Target (Type and Quantity) (D-2)		(D-3)	Assumptions for providing inputs: (D-4)										
		<table style="width: 100%; border: none;"> <tr> <td style="text-align: center;">FX</td> <td style="text-align: center;">LC</td> </tr> <tr> <td style="text-align: center;">(\$000)</td> <td style="text-align: center;">(K000)</td> </tr> </table>	FX	LC	(\$000)	(K000)								
FX	LC													
(\$000)	(K000)													
4. (Furniture, Equipment, Supplies) (Training) (Clinic personnel) (Training Materials) (Studies/Surveys) (Salaries) (Headquarters)	1 set 450 - 10	<table style="width: 100%; border: none;"> <tr> <td style="text-align: center;">-</td> <td style="text-align: center;">188</td> </tr> <tr> <td style="text-align: center;">-</td> <td style="text-align: center;">1048</td> </tr> <tr> <td style="text-align: center;">-</td> <td style="text-align: center;">150</td> </tr> <tr> <td style="text-align: center;">-</td> <td style="text-align: center;">375</td> </tr> <tr> <td style="text-align: center;">-</td> <td style="text-align: center;">375</td> </tr> </table>	-	188	-	1048	-	150	-	375	-	375		
-	188													
-	1048													
-	150													
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-	375													
E. Evaluation	Mid-term & End of Project	<table style="width: 100%; border: none;"> <tr> <td style="text-align: center;">200</td> <td style="text-align: center;">-</td> </tr> </table>	200	-										
200	-													
F. Contingency		<table style="width: 100%; border: none;"> <tr> <td style="text-align: center;">744</td> <td style="text-align: center;">504</td> </tr> </table>	744	504										
744	504													
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Annex B

**P.I.D. APPROVAL CABLE
AND
DISCUSSION OF ISSUES**

DEPARTMENT OF STATE

TELEGRAM

JUN 25 12 55 PM 1982

VV MJA590ESC905
PP RUMJRV
DE RUENG #6314/01 1760533

ZNY UUUUU ZZH
F R 250347Z JUN 82
FM SECSTATE WASHDC

TO RUMJRV/AMEMBASSY RANGOON PRIORITY 8377-78
INFO RUMTEK/AMEMBASSY BANGKOK 2900

BT
UNCLAS STATE 176314

AIDAC BANGKOK FOR CONTROLLER AND RCMO

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TAMER	2

E.O. 12065: IVA

TAGS:

SUBJECT: BURMA PRIMARY HEALTH CARE II PID (462-0004)

REF: (A) RANGOON 2102 (B) RANGOON 1902 (C) STATE 45604

1. APAC MET JUNE 8 AND, BASED ON REF B AND THE MID-TERM-EVALUATION, APPROVED SUBJECT PID. PROJECT PAPER DESIGN SHOULD TAKE IN TO ACCOUNT FOLLOWING QUESTIONS/ISSUES RAISED AT APAC, IN ADDITION TO THOSE IDENTIFIED IN THE PID:

-- (A) PROPOSED DEVELOPMENT OF IN-COUNTRY PRODUCTION CAPABILITIES: APAC QUERIED IF THERE ARE FEASIBLE OPPORTUNITIES FOR PRIVATE SECTOR ENGAGEMENT, IN WHOLE OR PART, IN PRODUCTION AND BOTTLING OF RINGIER'S LACTATE; PRODUCTION AND PACKAGING OF ORT MATERIALS; OR PRINTING AND REPRODUCTION OF HEALTH/NUTRITION/ENVIRONMENTAL SANITATION EDUCATION MATERIALS. DESIGN TEAMS SHOULD EXPLORE FULLY THE PROSPECTS FOR PRIVATE SECTOR INVOLVEMENT IN EACH OF THESE AS WELL AS OTHER PROJECT RELATED AREAS.

-- (B) EXPANDED SCOPE OF PHC II: WHEREAS ASSISTANCE TOWARD EXPANSION OF DOMESTIC DRUG PRODUCTION CAPABILITIES APPEARS TO BE IN LINE WITH PHC I, APAC QUESTIONED WHETHER PRODUCTION OF ENVIRONMENTAL SANITATION COMMODITIES (I.E., LATRINE CONSTRUCTION KITS) MAY EXCEED MOST APPROPRIATE SCOPE, INTENT, AND ANALYTICAL BASIS OF THE PHC PROJECT. IN THIS CONTEXT, AID ASSISTANCE IN THE HEALTH SECTOR IS CURRENTLY DIRECTED TO REDUCING INFANT AND YOUNG CHILD MORBIDITY AND MORTALITY. DIARRHEAL DISEASES ARE AMONG THE PRINCIPAL CAUSES OF DEATHS IN THAT AGE GROUP. PHC I PROMOTED ORT AND NUTRITION IMPROVEMENT AS KEY INTERVENTIONS WITHIN THE HEALTH CARE SYSTEM STRATEGY, BOTH OF WHICH ARE PRIMARILY TECHNOLOGIES THAT CAN EFFICIENTLY REDUCE MORTALITY FROM THIS GROUP OF DISEASES. PHC II SHOULD PURSUE THIS STRATEGY BY STRENGTHENING THE ABILITY OF HEALTH CARE WORKERS TRAINED UNDER THE PROJECT TO

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IMPROVE THE QUALITY OF ORT AND NUTRITION CARE RENDERED BY MOTHERS DURING EPISODES OF DIARRHEA. PHC II COULD ADDRESS ENVIRONMENTAL SANITATION THROUGH: 1) DEVELOPMENT AND PRODUCTION OF RELATED EDUCATION MATERIALS ENCOURAGING PROPER USE AND MAINTENANCE OF WATER AND SANITATION FACILITIES 2) INCLUSION OF ENVIRONMENTAL HEALTH PRACTICES IN CHW CURRICULUM; AND/OR 3) PROVISION OF TA FOR PRODUCTION DESIGN ASSISTANCE PER PARA 3 REF B. ANY CONSIDERATION OF ENVIRONMENTAL SANITATION COMMODITIES PRODUCTION IN PHC II SHOULD FOLLOW LOGICALLY FROM THE OVERALL DIARRHEAL DISEASE CONTROL STRATEGY OUTLINED ABOVE AND SHOULD NOT SUBSTITUTE FOR OR COMPETE WITH RESOURCES REQUIRED TO IMPROVE AND EXPAND THE APPROACH BEGUN IN PHC I AND PLANNED FOR CONTINUATION IN PHC II. FURTHER, ANY SUCH COMPONENT WOULD NEED TO BE FULLY JUSTIFIED IN TERMS OF TECHNICAL, FINANCIAL, ECONOMIC (INCLUDING SUPPLY/DEMAND ANALYSES) AND ORGANIZATIONAL FEASIBILITY (INCLUDING OUTREACH, AND OPERATION AND MAINTENANCE METHODOLOGIES). FINALLY, APAC QUESTIONED PRODUCTION OF ENVIRONMENTAL SANITATION COMMODITIES IN ADDITION TO THE PROPOSED DEVELOPMENT OF OTHER PRODUCTION CAPACITIES MENTIONED IN PARA 1(A) ABOVE. FYI: PF DESIGN TEAM WILL BRING LATEST WATER SUPPLY AND SANITATION POLICY PAPER FOR GUIDANCE THIS SUBJECT.

--(C) REPLICABILITY/SUSTAINABILITY: STRONG APAC CONCERN WAS AGAIN RAISED OVER COST-RECOVERY FOR EPI DRUGS AT BOTH VILLAGE AND EPI LEVELS. PF TEAM SHOULD FOCUS ON EXPERIENCE TO DATE AND LESSONS LEARNED FROM PHC I. VILLAGE

CONTRIBUTIONS AND CAPABILITY OF HEALTH CARE STAFF TO RECOVER COSTS FOR REPLENISHMENT AND EXPANSION OF DRUG SUPPLY ARE OF SPECIAL INTEREST HERE. RECURRENT COST IMPLICATIONS OF RAPIDLY EXPANDING PHC STAFF AND EPI PRODUCTION CAPACITY THUS WARRANTS THOROUGH PF TEAM EXAMINATION. SEE PARA 5 REF C FOR FURTHER GUIDANCE.

--(D) TECHNICAL ASSISTANCE: REF B ENCOURAGING RE APPARENT BURMESE ACCEPTANCE OF LARGER AND LONGER TA PROJECT COMPONENT. NONETHELESS, APAC WAS CONCERNED THAT PROJECT SCOPE AND COMPLEXITY ARE SUCH AS TO REQUIRE PERHAPS A LARGER TA COMPONENT THAN NOW ANTICIPATED IN THE PID. PF ADMINISTRATIVE ANALYSIS SHOULD PRESENT REALISTIC PLAN, BUDGET AND SCOPE OF TA COMPONENT AS WELL AS AID/BURMA BACKSTOPPING CAPABILITY FOR PROJECT OF THIS SIZE AND COMPLEXITY.

--(E) COMMODITIES: ALTHOUGH APAC AGREED TO LEAVE THE COMMODITY REQUIREMENTS UP TO THE DISCRETION OF THE DESIGN TEAM WORKING IN CONJUNCTION WITH THE SRUC, CONCERN WAS EXPRESSED (IN LIGHT OF PAST PROBLEMS IN THIS REGARD) RE THE TIMELY ARRIVAL OF MATERIALS. PF SHOULD DESCRIBE MEANS OF ENSURING THAT DELIVERY OF COMMODITIES dovetails WITH PROJECT REQUIREMENTS. THIS IS ESPECIALLY IMPORTANT TO AVOID "DROP OUT" OF VOLUNTARY HEALTH WORKERS DUE TO LACK OF TIMELY SUPPLY OR RESUPPLY OF ESSENTIAL COMMODITIES NEEDED BY THEM TO PERFORM THEIR WORK.

Best Available Document

-- (F) COMMUNITY PARTICIPATION: PAST EXPERIENCE HAS TAUGHT US THE IMPORTANCE OF BENEFICIARY PARTICIPATION IN PROJECTS OF THIS TYPE. PP SHOULD DESCRIBE MEANS OF ASSURING MAXIMUM COMMUNITY INVOLVEMENT AND PARTICIPATION IN PLANNING, IMPLEMENTATION AND MONITORING OF THE PROJECT.

-- (G) HEALTH MONITORING SYSTEM: SINCE MID-TERM EVALUATION HIGHLIGHTED DEFICIENCIES IN CURRENT MONITORING AND EVALUATION SYSTEM, DESIGN TEAM SHOULD EXAMINE AND DEVELOP NECESSARY SYSTEM TO EFFECTIVELY MONITOR THE ACHIEVEMENT OF PROJECT PURPOSE AND GOAL. PP SHOULD ALSO DESCRIBE HOW EXPERIENCE UNDER THE PROJECT WILL BE REPORTED AND RECORDED, SO AS TO BE "FED-BACK" INTO PROJECT IMPLEMENTATION DURING THE LIFE OF PROJECT.

2. FUNDING IMPLICATIONS: WHILE PID WAS APPROVED UP TO DOLS 12.5 MILLION, POINT WAS MADE THAT WITH SWITCH TO MORE PREVENTIVE AND LESS CURATIVE CARE, IT IS QUITE

POSSIBLE THAT NOT ALL THAT AMOUNT MAY BE NEEDED FOR PHC II. PP DESIGN SHOULD FULLY JUSTIFY TOTAL PROJECT FUNDING REQUIREMENTS AS WELL AS COST OF INDIVIDUAL PROJECT COMPONENTS.

3. RE PARA 4 REF 1, FY 82 PDS FUNDS RESERVED AS FOLLOWS:
DOLS 25,000 FOR EDIBLE OILS EXTRACTION TECHNOLOGY STUDY
AND DOLS 25,000 FOR CONSULTANT SERVICES FOR PHC II PP DESIGN.

4. SEPTEL SENT RE PP DESIGN TEAM COMPOSITION AND TIMING.

HA16
BT
#6314

Primary Health Care II

Issues Raised by APAC During PID Review

The following issues concerning the design and implementation of the Primary Health Care II project were raised by the Asia Projects Advisory Committee in June 1982. Most have been resolved and are touched upon in various parts of the PHC II Project Paper. This exhibit summarizes AID/Burma's findings in trying to resolve all issues or questions raised during the APAC PID review.

A. Domestic Pharmaceutical Production

The production of pharmaceuticals in Burma is influenced by a set of factors that AID cannot influence directly through this project. All drugs and pharmaceuticals manufactured in Burma come from the state-run Burma Pharmaceuticals Industry (BPI). In trying to schedule production runs BPI faces these problems:

1. BPI plant production capacity is very limited;
2. Foreign exchange, which is needed to import raw materials, is also very limited;
3. BPI, as a state corporation, is expected to show a profit; this leads to limited production of drugs and pharmaceuticals for which there is only a small market, compared to patent medicines, lotions/tonics, balms etc., which are in popular demand.

In Burma, no private sector alternative to BPI exists at the moment. However, several donors, including the United Kingdom, Japan and West Germany are exploring ways to assist BPI expand plant capacity and to produce, bottle and distribute critical products like Ringers Lactate and oral rehydration salts (ORS). In light of such donor interest, and because AID's resources are so limited, it is not advisable for AID/Burma to pledge PHC II project funds for BPI improvements.

B. Replenishment of Drugs

Experience with Primary Health Care I shows that villagers are financially able to pay for the replenishment of drugs and supplies used by community health workers. Every area visited by AID and Department of Health staff has a system for collecting monies to buy drugs and almost all have said that they had four to six hundred kyat available. The main problem is not money; it's the actual and timely availability of drugs and pharmaceuticals as discussed in A above. Most villages find replenishment items with only minor difficulty, either through the cooperatives system (BPI manufacture) or from the open market; the latter option is

often more expensive. The Department of Health, BPI and the Ministry of Cooperatives continue to explore improvements in the distribution of pharmaceuticals and in the collection of funds. The fact that Village Councils find innovative ways and means to raise funds and secure drugs, though, is a clear indication of strong community support for primary health care in Burma.

C. Environmental Sanitation Intervention

After careful consideration, AID/Burma and the Department of Health have decided that the provision of water seal latrine construction kits is not practical under this project. The reasons for this decision are several; first plastic privy molds are expensive; second, water is not readily available throughout the country; third cement is expensive and hard to find and fourth, alternative, low cost privy designs are possible, i.e., a pit privy with bamboo or thatch walls and roof. Increased emphasis will be placed on village sanitation techniques during volunteer health worker training. Low cost techniques include covering drinking water receptacles, encouraging the use of pit privies using locally available materials, keeping draft animals away from living areas as much as possible and eliminating stands of stagnant water which can spawn mosquito larva. Oral rehydration therapy will also be given special emphasis during training.

D. Technical Assistance

AID/Burma believes that AID-financed technical assistance, as described in the inputs section of Part II, is adequate to carry out project objectives and monitor AID investment and is the maximum that can be achieved in negotiation in the Burmese political context, at this time. Some 107 person months of technical assistance valued at \$1,297,000 have been carefully negotiated with the Department of Health and agreement has been reached, subject to the review of higher authorities, to concentrate TA, over the life of the project on volunteer health worker training, health information systems and on the family health counseling initiative. During negotiations, the concept of a single contract with a U.S. consulting firm has emerged. Under the concept, one highly skilled and motivated long-term consultant will serve as the advisor on revamping volunteer health worker training and he/she will also coordinate the range of short-term consultants brought in for periods of one to six months, but who will return at regular intervals. The key variable in this approach is the quality of consultants, in terms of technical skills and cultural sensitivity. Quality must be high. Only U.S. health management consultant firms with a proven record of accomplishment should be considered for such a single, comprehensive and critical contract.

AID/Burma and the Department of Health prefer a single contract for TA which can provide a broad range of services for the project, thereby establishing a working knowledge of Burmese health conditions. The long-term training consultant, in his/her capacity as TA Team Leader, will work closely under the supervision of the AID/Burma USDH Public Health Officer and the Burmese Government Project Director. Other AID USDH management inputs to PHC II will be provided by the AID/Burma Program Officer who is a full-time member of the PHC II Project Committee and by Regional AID officers; the RLA in Colombo, the USAID/Burma Controller in Bangkok, the RCMO in Bangkok and the RCO in Manila.

E. Delivery of Commodities

AID/Burma recognizes, and is concerned about, the prompt delivery of volunteer health worker equipment and supplies. To this end, PHC II will continue to purchase health worker kits from UNICEF, for which source/origin and sole source waivers will be sought, as in PHC I. AID/Burma has also investigated the possibility of ordering directly from UNIPAC/Copenhagen which could shorten delivery lead time by 6 to 8 months. Direct procurement from Copenhagen to Rangoon will require a UNICEF/Rangoon and Department of Health "Reimbursible Procurement Agreement" by which mechanism the DOH can request UNICEF to furnish items directly from its shelves, to be paid for by AID through the USAID/Controller in Bangkok, or by AID/W into UNICEF's New York account. A statement of intent will be requested from UNICEF that non-Code 935 items in the health workers' kits (generally no more than one or two items) can be separated and US manufactured items substituted in Rangoon by the Department of Health. Discussions are progressing with UNICEF on these procurement mechanisms.

F. Health Project Monitoring Systems

AID/Burma does not believe that a health information system, that can guarantee the data needed for impact evaluation, will be developed in Burma in the near future. Accordingly, this project will continue the work begun under PHC I. A list of impact indicators is being developed by AID/Burma and the Department of Health. In Burma, it is necessary to develop a data processing capability simultaneously with the data collection system. Technical assistance to the DOH's Health Information Service will help to develop a system that can track the following illustrative list of impact indicators.

1. Nutritional Status of Under-five Children Under growth surveillance
 - Numbers of children by age
 - Number gaining weight
 - Number failing to gain weight
 - Defaulters to the system

2. Diarrheal Disease Surveillance

- Number of children with diarrheal episodes
- Type of treatment
- Referred to rural health center or Station Hospital
- Number of Deaths

3. Pregnancy

- Number of new pregnant women
- Number of pre-natal visits
- Out come of deliveries
- Number of maternal and neo-natal deaths
- Number of pregnant mothers referred to hospital
- Number of Hospital admissions for neo-natal tetanus

4. Family counseling

- Number of contraceptive acceptors by method
- Number of contraceptive method changers
- Defaulters
- Estimate of the number of method failures.

Annex C

PROJECT BACKGROUND DATA

ANNEX C

PROJECT BACKGROUND DATA

TABLE ONE

LEADING CAUSES OF ADMISSION IN 399 TOWNSHIP HOSPITALS (1977)

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

TABLE TWO

LEADING CAUSES OF DEATH IN 399 TOWNSHIP HOSPITALS (1977)

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

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

TABLE THREE
ESTIMATES OF POPULATION BY AGE (IN MILLIONS)

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

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

TABLE FOUR
HEALTH FACILITIES

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

* Including 287 rural township hospitals

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

TABLE FIVE
HEALTH TRAINING INSTITUTIONS

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

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

TABLE SIX
MANPOWER RESOURCES (1977)

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

* Estimated

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

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TABLE SEVEN

PEOPLE'S HEALTH PROGRAMME PRIORITIES

Major Programmes

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

Support Projects

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

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

TABLE EIGHT

PEOPLE'S HEALTH PROGRAMME TARGETS

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

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

TABLE NINE
ACTIVITIES OF AUXILIARY MIDWIFE

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

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

TABLE TEN
ACTIVITIES OF COMMUNITY HEALTH WORKER

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

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

PROJECT FUNDING TABLES

AID Dollar Grant
(PROJECT BUDGET SUMMARY)

Item	Total	1983/84	1984/85	1985/86
I. VHW Training/Deployment				
Technical Assistance	636	539	97	
Equipment and Supplies	4,127	2,199	1,615	313
Participant Training	<u>322</u>	<u>46</u>	<u>230</u>	<u>46</u>
Sub-Total	5,085	2,784	1,942	359
II. H.I.S.				
Technical Assistance	211	74	74	63
Participant Training	<u>135</u>	<u>-</u>	<u>35</u>	<u>100</u>
Sub-Total	346	74	109	163
III. D.O.H. Management				
Participant Training	<u>764</u>	<u>217</u>	<u>246</u>	<u>131</u>
Sub-Total	764	217	246	131
IV. Family Health Counseling				
Technical Assistance	446	254	96	96
Equipment and Supplies	2,202	1,052	400	750
Participant Training	<u>213</u>	<u>128</u>	<u>75</u>	<u>10</u>
Sub-Total	<u>2,861</u>	<u>1,454</u>	<u>571</u>	<u>856</u>
Sub-Total	9,056	4,644	2,903	1,509
V. Evaluation				
Evaluation	200			200
VI. Contingency				
Contingency	<u>744</u>	<u>456</u>	<u>97</u>	<u>191</u>
Grand-Total	10,000	5,100	3,000	1,900

100

AID Dollar Grant
(DETAILED PROJECT BUDGET BREAKOUT)

INPUTS	Total	1983/84	1984/85	1985/86
I. VHW TRAINING/DEPLOYMENT				
A. Technical Assistance				
1. Training Advisor (1983-1984) 24 pm @ 12,500	345	345		
2. A/V and Video Trainer (1984) 6 pm @ 14,000	97	97		
3. Ed. Methods Advisor (1983-84) 12 pm @ 14,000	<u>194</u>	<u>97</u>	<u>97</u>	
Sub-Total	<u>636</u>	<u>539</u>	<u>97</u>	
B. Equipment and Supplies				
1. AMW Kits (1300) (1500) @ \$41.15	139	65	74	
AMW Kit cases (5600) @ \$ 8.00	54	27	27	
2. CHW Kits (4100) (4100) @ \$85.00	840	420	420	
3. AMW Medicine Kits (2800) (2800) @ \$109.00	611	305	305	
4. TBA Kits scales (6000) (6000) @ \$ 20.00	288	144	0	144
5. Scales (3000) (3000) @ \$30	180	90	90	
6. Drugs (Initial supply)	676	338	169	169
7. RHC Equipment (140) (140) @ \$304.33	104	52	52	
8. Sub-center Equipment (560) (560) @ \$50.42	56	28	28	
9. Station Hosp: equipment (20) (20) @ \$12,500	600	300	300	
10. Training equipment/A/V & Video	250	100	150	
11. Vehicles S/DTT/F.H.C. (22) @ \$15,000	<u>330</u>	<u>330</u>		
Sub-Total	4,127	2,199	1,615	<u>313</u>

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INPUTS

Total 1983/84 1984/85 1985/86 1986/87

C. Participant Training

(Academic @ \$2,400/Mo)

(Short-term @ \$5,000/Mo)

1. Health Ed. (MPH): One (1984) 18 Mo.	50		50	
2. Health Ed. (MPH): Nurse: One (1984) 24 Mo.	67		67	
3. E.D. Science (Msc.): Nurse: One (1984) 24 Mo.	67		67	
4. E.D. Techniques: 2/yr X 3 X 4 Mo. (1983/84/85)	<u>138</u>	<u>46</u>	<u>46</u>	<u>46</u>
Sub-Total	322	46	230	46

II. HEALTH INFORMATION SERVICES

A. Technical Assistance

1. Health Information Specialist (1983/84/85) 12 pm @ \$5,000/Mo.	70	17	17	35
2. Evaluation Research (1983/84) 8 pm @ \$5,000/Mo.	45	23	23	
3. Computer Specialist (1983/84/85) 9 pm @ \$500/Mo.	52	17	17	17
4. Data Analyst (1983/84/85) 8 pm @ \$5,000/Mo.	<u>46</u>	<u>17</u>	<u>17</u>	<u>11</u>
Sub-Total	211	74	74	63

C. Participant Training

1. Biostatistics (MPH) (1985) One: 18 Mo.	50			50
2. Computer Science (MSc). (1985) One: 18 Mo.	50			50
3. Health Statistics/Demography (1984) One X 6 Mo.	<u>35</u>		<u>35</u>	
Sub-Total	135		35	100

INPUTS	Total	1983/84	1984/85	1985/86	1986/87
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III. DOH MANAGEMENT/SUPERVISION

C. Participant Training (Academic)

1. Health Admin. (PhD.) (1984) One: 36 Mo.	99	99			
2. Health Admin. (MPH) (1985) One: 18 Mo.	50		50		
3. M.C.H. (MPH) (1984/85/86) Three: 18 Mo.=54 Mo.	150	50	50	50	
4. Epidemiology (PhD.) (1984) One: 36 Mo.	99	99			
5. Epidemiology (MPH) One: 18 Mo.	50		50		
6. Environmental Sci. (Eng) (MSc) (1985) One: 18 Mo.	50		50		
Short-term					
7. M.C.H. (1984/85/86) 2 X 4 Mo. X 3 yrs = 24 Mo.	138	46	46	46	
8. Health Planning/MGT.(1984/85/86) 1 X 6 Mo X 3 years = 18 Mo.	105	35	35	35	
9. Environmental Health (1984) One: 4 Mo.	<u>23</u>	<u>23</u>			
Sub-Total	764	352	281	131	

IV. FAMILY HEALTH COUNSELING

A. Technical Assistance

1. Contraceptive Technology Specialists 2 X ½ pm (1983) @ \$14,000/Mo.	14	14			
2. Service Date Records Specialist (1983) 1 pm	14	14			
3. Training Advisor (1983/84/85) 10 pm @ \$14,000/Mo.	160	64	48	48	
4. Specialist in Family Counseling Service Programs: (1983/84/85) 10 pm @ \$14,000	160	64	48	48	

INPUTS	Total	1983/84	1984/85	1985/86	1986/87
5. Medical Demographer (1983 or 1984) 3 pm @ \$14,000	49	49			
6. Information/Education Advisor (1983) \$14,000	49	49			
Sub-Total	446	254	96	96	
B. Equipment/Supplies					
1. Paper, Ink, Stationery	200	200			
2. Clinic Equip/Supplies	450	450			
3. Contraceptive	1,300	200	350	750	
4. Medical Kits: No.1 770 @ 85	78	78			
No.8 70 @ 170	14	14			
Infertility 25 @ 825	25	25			
5. IUD (C-T 200B)	100	50	50		
6. Office Equipment/Air conditioners	30	30			
7. Library	5	5			
Sub-Total	2,202	1,052	400	750	
C. Participant Training					
1. Observation Tour (Asia Reg.) 12 pm (1983/84/85) 4 Mo. X 3yrs	30	10	10	10	
2. Management Training (1983) 6 pm @ \$5,000/Mo.	30	30			
3. MPH or Equiv. Family Counseling (1984/85) @ \$2,400 2 X 18 Mo.	100	50	50		
4. Training of Trainers (1983) 4 pm @ \$5,000	23	23			
5. Other Short-term Training (1983-84) 2 X 3 Mo. @ \$5,000	30	15			
Sub-Total	213	128	75	10	

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INPUTS	Total	1983/84	1984/85	1985/86	1986/87
V. EVALUATION					
Mid-term Evaluation late 84 or early 85 (6 pm)	200			200	
VI. CONTINGENCY	744	456	97	191	
GRAND-TOTAL	10,000	5,100	3,000	1,900	

Annex E

**PROJECT FUND ACCOUNT (AID)
KYAT BUDGET**

PROJECT FUND ACCOUNT (AID)
Kyat Budget
for
Primary Health Care II Project (482-004)
(in 000's)

(Exhibit 1)

<u>I. VHW Deployment</u>	<u>1983/84</u>	<u>1984/85</u>	<u>1985/86</u>	<u>TOTAL</u>
A. Pre-Service Training of Village Health Workers				
1. <u>AMWs</u>				
a. Per diem (K10/day X 180 days X 2701: 319,746,743,893)	1,620.6	1,620.6	1,620.6	4,861.8
b. Other costs (rents, transport, subsistence supplies: K300/town x 125: 19, 33, 29, 44)	12.5	12.5	12.5	37.5
2. <u>CHWs</u>				
a. Per diem (K15/day X 30 days X 8000: 2,000 per year)	1,200	1,200	1,200	3,600.0
b. Other costs (rents, transport, subsistence supplies: K100/RHC X 5 RHCs per township: 48, 42, 46, 43).	27.8	27.8	27.8	53.50
SUB-TOTAL	2,860.9	2,860.9	2,860.9	8,582.8 (rounded to 8,583.0)

100

<u>ITEM</u>	<u>1982/83</u>	<u>1983/84</u>	<u>1984/85</u>	<u>1985/86</u>	<u>TOTAL</u>
B. In-Service Training of Village Health Workers					
1. <u>AMWs</u>					
Per diem (K10/day x 6 days every other year) as follows:					
classes prior to 82/83 (4600)	---	276.0	---	276.0	552.0
classes of 82/83 (1,100)	---	---	66.0	---	66.0
classes of 83/84 (1,500)	---	---	---	90.0	90.0
2. <u>CHWs</u>					
Per diem (K10/day x 6 days per year) as follows:					
classes prior to 82/83 (13,958)	---	837.48	837.48	837.48	2,512.44
classes of 82/83 (4,100)	---	246.0	246.0	246.0	738.0
classes of 83/84 (4,100)	---	---	246.0	246.0	492.0
SUB-TOTAL	---	<u>1,359.48</u>	<u>1,395.48</u>	<u>1,695.48</u>	<u>4,450.44</u> (rounded to 4,451)

<u>ITEM</u>	<u>1983/84</u>	<u>1984/85</u>	<u>1985/86</u>	<u>TOTAL</u>
6. Let-The Training				
1. Per diem (K10/day X 30 days X 12,000: 3,000 per year)	1,200.0	1,200.0	1,200.0	3,600.0
2. Training expense (K700/township X 147 townships: 49 per year)	34.3	34.3	34.3	102.9
3. Training materials (K50/set X 5,500 trainers)	91.6	91.6	91.6	274.8
4. Traveling allowance (K400/township X 147 Townships)	19.6	19.6	19.6	58.8
SUB-TOTAL	<u>1,345.5</u>	<u>1,345.5</u>	<u>1,345.5</u>	<u>4,036.5</u> (rounded to 4,037)
D. Division/State Training Teams				
1. Salaries 17 Physicians (K800/mo)	163.2	163.2	163.2	459.6
2. 19 P.H.N. (K600/mo)	136.8	136.8	136.8	410.4
3. 1 Secretary/Typist	3.6	3.6	3.6	10.8
4. 18 Drivers	43.2	43.2	43.2	129.6
5. Per diem (K10 per person X 66 persons X 8 trips of 15 days each/year)	79.2	79.2	79.2	237.6
6. Travel allowance (K50/trip X 8 trips/year X 66 persons)	26.4	26.4	26.4	79.2
7. Supplies	30.0	30.0	30.0	120.0
8. Contingency 6000 X 16 vehicles Drivers 200 X 12 X 18 X 3	96.0	96.0	96.0	288.0
SUB-TOTAL	<u>588.4</u>	<u>588.4</u>	<u>588.4</u>	<u>1,765.2</u> (rounded to 1,765.0)

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	<u>1983/84</u>	<u>1984/85</u>	<u>1985/86</u>	<u>TOTAL</u>
E. Village People's Council Orientation				
1. Per diem (K10/day X 2 days X 2 persons X 10 orientations each year)				
as follows:				
4,000 CHWs + 10-65 Counselors	186	-	-	186
2,000 CHWs + 743 Counselors	-	93	-	93
2,000 CHWs + 893 Counselors	-	-	99	99
	<hr/>	<hr/>	<hr/>	<hr/>
SUB-TOTAL	186	93	99	378
				(round to 378)

F. Materials Production				
1. Printing of health education materials	46.6	46.6	46.6	139.8
2. AMW Manuals (K10 X 10,000)	30.0	30.0	40.0	100.0
3. CHW Manuals (K15 X 12,000)	100.0	100.0	100.0	300.0
4. TBA Trainer's Manual (K10 X 5,500)	18.3	18.3	18.3	54.9
5. Trainer's Guides for CHW & AMW training	40.0	20.0	20.0	80.0
6. Printing of curricula	40.0	20.0	20.0	80.0
7. Printing of Pharmaceutical handbooks for CHWs	200.0	100.0	100.0	400.0
	<hr/>	<hr/>	<hr/>	<hr/>
SUB-TOTAL	474.9	334.9	344.9	1,154.7
				(round to 1,155)

<u>II. Health Information System/Research</u>	<u>1983/84</u>	<u>1984/85</u>	<u>1985/86</u>	<u>TOTAL</u>
A. Studies, Surveys, Workshops	<u>276.0</u>	<u>138.0</u>	<u>138.0</u>	<u>552.0</u>
	276.0	138.0	138.0	552.0
B. HIS Personnel				
1. Central Office Salaries				
a. Maintenance engineer (K6,480/year)	6.48	6.48	6.48	19.44
b. Programmers (K3,280/yr. X 2 persons)	9.72	9.72	9.72	29.16
c. Statistical Technicians (K4,800/yr. X 8 persons)	<u>38.4</u>	<u>38.4</u>	<u>38.4</u>	<u>115.2</u>
	54.60	54.60	54.60	163.80
2. Offset Personnel				
a. Machine Operator (K4,860/year)	4.86	4.86	4.86	14.58
b. Camera Technician (K4,860/year)	4.86	4.86	4.86	14.58
c. Asst. Machine Operator (K3,480/year)	3.48	3.48	3.48	10.44
d. Asst. camera technician (K3,480/year)	3.48	3.48	3.48	10.44
e. Binding technician (K2,700/year)	2.70	2.70	2.70	8.10
f. Messengers (K2,160/yr. X 2 persons)	<u>4.32</u>	<u>4.32</u>	<u>4.32</u>	<u>12.96</u>
	23.70	23.70	23.70	71.10
3. State/Division Statistical Technicians				
a. Salaries (K4,800/yr. X 15 persons)	72.0	72.0	72.0	216.0
b. Per diem (K10/day X 12 trips of 5 days each X 22 persons /year)	<u>9.0</u>	<u>9.0</u>	<u>9.0</u>	<u>27.0</u>
	81.0	81.0	81.0	243.0

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c. Travel allowance (K50/trip X 12 trips X 15 persons)	9.0	9.0	9.0	27.0
d. Rangoon Workshop: Per diem: K16/day X 15 days X 15 persons	2.25	2.25	2.25	6.75
e. Travel allowance (K200 X 15 persons)	<u>3.0</u>	<u>3.0</u>	<u>3.0</u>	<u>9.0</u>
	14.25	14.25	14.25	42.75

4. Incentives for Data Collection

a. AMWs (K50 m X 204 persons X 48 m)	122.4	122.4	122.4	367.2
b. CHWs (K50 m X 468 persons X 48 m)	<u>280.8</u>	<u>280.8</u>	<u>280.8</u>	<u>842.4</u>
	403.2	403.2	403.2	403.2

III. DOH Management/Supervision

A. Project Headquarters

1. Salaries

Accountant (K700/mo)	8.4	8.4	8.4	25.2
Secretary/typist (300/mo)	3.6	3.6	3.6	10.8
2 Asst. Accountants (400 X 12 X 3)	9.6	9.6	9.6	28.8

2. Travel

(K600/trip X 5 trips X 2 staff each year)	6.0	6.0	6.0	18.0
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3. Equipment/Supplies

	<u>15.0</u>	<u>15.0</u>	<u>15.0</u>	<u>45.0</u>
	42.6	42.6	42.6	127.8

(rounded to 128.0)

B. Bicycles for BHS Staff
(K1,000/bikes X 4,650 bikes)

	1,550.0	1,550.0	1,550.0	<u>4,650.0</u>
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C. Buildings

1. CMSD Warehouse	330.0	-	-	330.0
2. Nutrition Building	3,000.0	-	-	3,000.0
3. Family Counseling	<u>500.0</u>	-	-	<u>500.0</u>
	3,830.0			3,830.0

D. Logistics Staff

1. Logistics Officer	8.4	8.4	8.4	25.2
2. Asst. Logistics Officer	<u>9.6</u>	<u>9.6</u>	<u>9.6</u>	<u>28.8</u>
	18.0	18.0	18.0	54.0

SUB-TOTAL

8,662.0

IV. Family Health Counseling

A. Furniture, Equipment Supplies	70.0	60.0	58.0	188.0
B. Training	350.0	349.0	349.0	1,048.0
C. Training Materials	75.0	50.0	25.0	150.0
D. Studies/Surveys	100.0	150.0	125.0	375.0
E. Salaries	<u>125.0</u>	<u>125.0</u>	<u>125.0</u>	<u>375.0</u>
SUB-TOTAL	13,840.0	9,694.0	9,958.0	33,498.0
Contingency	<u>167.0</u>	<u>167.0</u>	<u>167.0</u>	<u>502.0</u>
GRAND-TOTAL	14,007.0	9,861.0	10,125.0	34,000.0

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A.I.D. Project Number 482-0002

AMENDMENT NUMBER THREE
to
PROJECT GRANT AGREEMENT
for the
PRIMARY HEALTH CARE PROJECT

Dated January , 1983

Between

The Government of the Socialist Republic of the Union of Burma
("Grantee")

And

The Government of the United States of America, acting through the
Agency for International Development ("A.I.D.").

WHEREAS, the Grantee and A.I.D. entered into a Project Grant
Agreement dated August 29, 1980, for the Primary Health Care Project,
and thereafter amended the said Agreement by Amendment No. One, dated
December 12, 1980, and Amendment No. Two, dated September 30, 1982;

WHEREAS, the Grantee has requested that A.I.D. provide an additional
grant of United States Government-owned Burmese kyats to assist in
financing additional programs of economic and social development in the
health sector of Burma that will directly enhance the development benefits
of the Project; and

WHEREAS, the Grantee and A.I.D. desire to amend the above-captioned
Agreement to provide funds for such an additional grant and to add
provisions relating to disbursement of the total amount of the kyat grant;

NOW, THEREFORE, the parties hereby further amend the said Agreement
as follows:

1. Article 2: The Project

Section 2.1. Definition of the Project

Add a new second sentence to this section reading as follows:
"The Project will also include local currency support to assist in

accelerating the Agricultural Mechanization Department's rural potable water supply program, with priority to be given to villages that are near rural health centers, and establishment of a project fund of Burmese kyats for use in meeting anticipated local costs of the Health Department's proposed Primary Health Care II Project or for other mutually agreed additional activities in the health sector of Burma that will directly contribute to achieving the goals of the current project."

2. Article 3: Financing

(a) Section 3.1. A.I.D. Contribution

By this Amendment, A.I.D. agrees to grant to the Grantee, for the additional purposes described in the language added above to Section 2.1 of the Agreement, Forty-One Million Seven Hundred Forty-Eight Thousand Kyats (K41,748,000). Kyat 7,748,000 of that sum will assist in financing an acceleration of the Agricultural Mechanization Department's rural water supply program, and Kyat 34,000,000 will be deposited in a project fund account in the name of the Grantee for use in meeting anticipated local costs of the proposed Primary Health Care II Project.

Section 3.1 of the Agreement is accordingly amended as follows:

Delete paragraphs (b) and (c) of the section in their entirety and substitute the following:

"(b) To assist the Grantee to meet the local currency costs of carrying out the Project, A.I.D., pursuant to the Agricultural Trade Development and Assistance Act of 1954 (P.L. 480), as amended, agrees to grant to the Grantee under the terms of this Agreement, as amended, Fifty-One Million Two Hundred Forty-Six Thousand Kyats (K51,246,000) ("Kyat Grant"). The Kyat Grant is composed of three parts:

Part A: Nine Million Four Hundred Ninety-Eight Thousand Kyats (K9,498,000), added by Amendment No. Two to the Agreement to assist in financing the Health Department's budgeted costs of the Project;

Part B: Seven Million Seven Hundred Forty-Eight Thousand Kyats (K7,748,000), added by Amendment No. Three to the Agreement to assist in financing an acceleration of the Agricultural Mechanization Department's rural water supply program commencing in fiscal year 1982/1983 of the Grantee; and

Part C: Thirty-Four Million Kyats (K34,000,000), added by Amendment No. Three to the Agreement for the purpose of establishing a project fund of Burmese kyats to be used in meeting anticipated local costs of the Health Department's proposed Primary Health Care II Project or for other mutually agreed additional activities in the health sector of Burma.

Total: Fifty-One Million Two Hundred Forty-Six Thousand Kyats (K51,246,000).

Parts A and B of the Kyat Grant may be used to finance the local currency costs, as defined in Section 6.2, of goods and services required for the Project, and Part C of the Kyat Grant shall be used to establish the project fund described in Section 2.1. The entirety of the Kyat Grant, including Parts A, B, and C (less any amounts previously disbursed to the Grantee under Part A), shall be disbursed to the Grantee within thirty (30) days after the date of Amendment No. Three to the Agreement and deposited in a project fund account in the Grantee's name in accordance with Section 7.2(b).

"(c) Eligible local currency costs, as more specifically defined in Project Implementation Letters, may be financed under Part A of the Kyat Grant commencing from the beginning of the Project and under Part B of the Kyat Grant commencing from the beginning of fiscal year 1982/1983 of the Grantee. Expenditures for such costs made out of kyat funds provided by the Grantee prior to, or after, the execution of Amendment No. Two or Amendment No. Three to this Agreement are therefore eligible for reimbursement out of Parts A and B, respectively, of the Kyat Grant, provided that such expenditures conform to the terms of this Agreement, as amended, and are not subject to reimbursement or financing under any other external loan, grant, or credit available to the Grantee.

"(d) Wherever used in this Agreement, the term "Grant" shall mean the Dollar Grant and Kyat Grant in the aggregate."

(b) SECTION 3.2. Grantee Contribution

Insert a new second sentence in paragraph (a) of this section reading as follows: "The Grantee also agrees to provide or cause to be provided, from sources other than the Kyat Grant, all Burmese kyats needed to finance any remaining local currency costs of (1) the Agricultural Mechanization Department's rural water supply program during the life of this Project, and (2) the proposed Primary Health Care II Project, if it is approved by the parties, or any other additional activities in the health sector of Burma that may be financed, in whole or in part, by mutual agreement under the Kyat Grant."

(c) SECTION 3.3. Project Assistance Completion Date ("PACD")

Add the following sentence to paragraph (a) of this section:

"The PACD specified above shall not, however, apply to Part C of the Kyat Grant. The PACD applicable to that part of the Grant will be specified in the Agreement for the Primary Health Care II (PHC II) Project, if and when agreement to proceed with that project is reached. If no agreement to proceed with the PHC II project is reached by September 30, 1983, the parties will establish a PACD for Part C of the Kyat Grant as part of a jointly agreed Project Implementation Letter relating to other additional activities in the health sector of Burma to be financed under Part C of the Kyat Grant."

3. Article 6: Procurement Source

SECTION 6.2. Local Currency Costs

Add a new sentence to this section reading as follows: "To the extent provided for under this Agreement, "Local Currency Costs" may also include the provision of local currency resources for the project fund described in Section 2.1 and the project fund account described in Section 7.2(b)."

4. Article 7: Disbursement

SECTION 7.2. Disbursement for Local Currency Costs

Insert "(a)" immediately after the caption and before the text of this section and add the following new paragraph (b):

"(b) Within thirty days after the date of Amendment No. Three to the Agreement, the full amount of the Kyat Grant, namely Fifty-One Million Two Hundred Forty-Six Thousand Kyats (K51,246,000) (less any amounts previously disbursed to the Grantee under part A of the Kyat Grant), will be disbursed by negotiable instrument payable to the Grantee, and, within three work days after receipt by the Grantee, will be deposited in a project fund account to be opened, for purposes of this Agreement, in the name of the Grantee at the Union of Burma Bank in Rangoon (the "Project Fund Account"). No request by the Grantee for this disbursement is required. The Grantee agrees that, except as A.I.D. may otherwise agree in writing, (1) all of Parts A, B, and C of the Kyat Grant deposited in the Project Fund Account or withdrawn from it shall be used solely for the purposes of those respective parts of the Kyat Grant, in conformity with this Agreement and jointly agreed Project Implementation Letters, and (2) all withdrawals of such funds from that Account shall be made in conformity with procedures to be set forth in jointly agreed Project Implementation Letters under this Agreement."

5. Article 8: Miscellaneous

(a) SECTION 8.1. Communications

Delete the address now shown for the Grantee and substitute the following:

"(1) On all matters relevant to this Agreement, other than the matters referred to in paragraph (2) below:

Director General
Department of Health
Rangoon

"(2) On all matters directly relevant to the establishment, operation, and status of funds in the Project Fund Account referred to in Section 7.2(b):

Director General
Budget Department
Ministry of Planning and Finance
Rangoon

cc: Director General
Foreign Economic Relations Department
Ministry of Planning and Finance
Rangoon"

(b) SECTION 8.2. Representatives

Insert new second and third sentences in this section reading as follows: "After the date of Amendment No. Three to the Agreement, however, the Grantee will be represented as follows: (1) For all purposes relevant to this Agreement, other than the matters referred to in (2) below, by the individual holding or acting in the office of Director General, Department of Health, and (2) On all matters directly relevant to the establishment, operation, and status of funds in the Project Fund Account referred to in Section 7.2(b), by the individual holding or acting in the office of Director General, Budget Department, Ministry of Planning and Finance. The representatives designated in or pursuant to this section shall be deemed to have full authority to sign on behalf of their respective Governments all jointly agreed Project Implementation Letters under this Agreement."

6. Annex 1, Amplified Description of the Project

The authorized representatives of the parties designated in Section 8.2 will revise, by jointly agreed Project Implementation Letters, Annex 1 of the Agreement, including Tables One and Three of that Annex, to provide mutually agreed amplified project descriptions, together with estimates of the local currency contributions of the parties, relating to the additions to the Project described in paragraph 1 of this Amendment.

7. Except as amended herein, the Agreement between the Grantee and A.I.D., as heretofore amended, remains in full force and effect, and as amended herein, applies to all funds provided under the Agreement.

IN WITNESS WHEREOF, the Government of the Socialist Republic of the Union of Burma and the Government of the United States of America, each acting through its duly authorized representative, have caused this Amendment to be signed in their names and delivered as of the day and year first above written.

GOVERNMENT OF THE SOCIALIST REPUBLIC OF THE UNION OF BURMA

BY: _____

Deputy Minister
TITLE: Ministry of Planning and Finance

GOVERNMENT OF THE UNITED STATES OF AMERICA

BY: _____

Ambassador of the
TITLE: United States of America



AGENCY FOR INTERNATIONAL DEVELOPMENT

Annex E
Exhibit 3

OFFICE OF THE
REPRESENTATIVE TO BURMA

AMERICAN EMBASSY
RANGOON, BURMA

January , 1983

U Kyaw Myint
Director General
Budget Department
Ministry of Planning and Finance
Rangoon

Subject: Primary Health Care Project
AID Project No. 482-0002
Project Implementation Letter No. 12

Dear U Kyaw Myint:

The purpose of this Project Implementation Letter is to record the agreement of our two Governments, pursuant to Amendment No. Three to the Project Grant Agreement, on (a) the specific activities and facilities, and specific local currency costs, that will be financed in whole or in part from Part B of the Kyat Grant made available by the United States Government under that Amendment, and (b) provisions relating to the establishment of the Project Fund Account and to the withdrawal and disposition of Kyat Grant funds on deposit in it (initially the full amount of the Kyat Grant), including among other things procedures to be followed in withdrawing funds from that Account and in accounting for their ultimate use.

I. Activities, Facilities, and Costs to be Financed Under the Kyat Grant

A. Part A of the Kyat Grant

The activities, facilities, and costs agreed to be financed from the Kyat 9,498,000 that constitute Part A of the Kyat Grant are described in Annex 1 of the Project Grant Agreement as supplemented and amended by Project Implementation Letter No. 10 dated November 8, 1982.

B. Part B of the Kyat Grant

Part B of the Kyat Grant, namely, Kyat 7,748,000, will be used to assist in financing an acceleration of the Agricultural Mechanization Department's rural water supply program, particularly in Burma's dry zone where many villages have no potable water source. In implementing grant-financed activities, priority will be given to those villages that are near rural health centers and are within the target areas of the subject project or the proposed Primary Health Care II Project.

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Kyat Grant funds will be used to assist in financing the costs of constructing an estimated 1,542 tubewells, pipe-water supply works, and housing for construction workers; costs of equipment, spare parts, machinery, and supplies for such construction; costs of transporting materials to the dry zone; and maintenance and repair costs for the drilling rigs, village pumps, and hydrological equipment commencing from the beginning of SRUB Fiscal Year 1982/1983. Estimates of the costs to be financed from Part B of the Kyat Grant are provided in Table 1 below.

Table 1.

<u>Rural Water Supply Program Costs</u>	<u>Estimated Costs to be Financed from Kyat Grant</u>
Construction	K 1,242,000
Supplies, equipment, and machinery	5,206,000
Maintenance and repairs	<u>1,300,000</u>
Total	<u>K 7,748,000</u> =====

The SRUB will finance or cause to be financed, the costs of all salaries of personnel employed in the Agricultural Mechanization Department's rural water supply program and all costs of the program in excess of the amount of Part B of the Kyat Grant.

Additional details regarding the rural water supply program are found on pages 30-32 of the "Proposal for Burma Local Currency Grant Agreement for Project Support" dated July 1982.

C. Part C of the Kyat Grant

Part C of the Kyat Grant, namely Kyat 34,000,000, will be deposited in a Project Fund Account in accordance with Section 7.2 (b) of the project grant agreement for use in meeting anticipated local costs of the Health Department's proposed Primary Health Care II Project or for the other mutually agreed additional activities in the health sector of Burma that will directly contribute to achieving the goals of the current project.

If the parties mutually agree to proceed with the proposed Primary Health Care II Project, the specific activities, facilities, and costs to be financed under Part C of the Kyat Grant will be specified and described in the project grant agreement for that project. If no agreement to proceed with that project is reached by September 30, 1983, or such other date as A.I.D. may agree to in writing, the specific activities, facilities, and costs to be financed under Part C of the Kyat Grant will be specified and described in a jointly agreed Project Implementation Letter.

If no agreement to proceed with the proposed Primary Health Care II Project is reached within the period of time specified in the paragraph above, and if the two governments are then unable to agree upon specific uses in the health sector of Burma for all or any part of Part C of the Kyat Grant, the provisions of paragraph 10 of Part II of this Project Implementation Letter shall apply.

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D. Special Provisions Regarding the Above-Described Activities and Uses of the Kyat Grant

Kyat amounts for the individual line items in Table 1 may be adjusted up or down without A.I.D. approval. No adjustment may be made in the total amounts of the individual parts of the Kyat Grant, namely Parts A, B, and C, without prior A.I.D. approval in writing.

The activity descriptions and statements of the contributions to be made by the parties included in Sections A through C above, together with the first paragraph of this Section D, shall be deemed to be incorporated as a supplement to Annex One (Amplified Description of the Project) of the project Grant Agreement.

II. Provisions Relating to the Establishment of the Project Fund Account and to the Withdrawal and Disposition of Kyat Grant Funds on Deposit in that Account

Pursuant to Section 7.2 (b) of the Project Grant Agreement, the full amount of the Kyat Grant, namely kyat 51,246,000, less any amounts previously disbursed under Part A of the Kyat Grant, is to be disbursed, by negotiable instrument payable to the SRUB, within thirty days after the date of Amendment No. Three, and, within three work days after receipt of that negotiable instrument, it is to be deposited in a Project Fund Account to be opened, for purposes of the Agreement, in the name of the Government of the Socialist Republic of the Union of Burma (the "SRUB") at the Union of Burma Bank in Rangoon. No request by the SRUB to AID for that disbursement is required under the Agreement. The disbursement will be made by a U.S. Treasury Department check, which will be issued in Bangkok. Please advise AID/Burma as soon as possible of the name of the payee to be shown on that check.

Also pursuant to Section 7.2 (b) of the Agreement, the SRUB agrees that, except as AID otherwise agrees in writing, (1) all of the Kyat Grant deposited in the Project Fund Account or withdrawn from it shall be used solely for the purposes of the Kyat Grant, in conformity with the Agreement as amended and jointly agreed Project Implementation Letters, and (2) all withdrawals of such funds from that Account shall be made in conformity with procedures to be set forth in jointly agreed Project Implementation Letters.

The following paragraphs set forth the mutual understandings of the parties regarding the establishment of the Project Fund Account and the withdrawal and disposition of funds on deposit in it.

1. Kyat Grant funds shall be deposited and maintained in a separate bank account that will be opened and maintained, for purposes of the Project, in the SRUB's name, at the Union of Burma Bank in Rangoon. The kyat grant funds that are to be disbursed to the SRUB under the Project Grant Agreement for the Maize and Oilseeds Production Project (A.I.D. Project No. 482-0005) for deposit in a similar project fund account and the Kyat Grant funds that are to be disbursed to the SRUB under the Agreement for

the subject Project for deposit in such an account may be deposited and maintained in the same bank account, or in two separate bank accounts, at the SRUB's option. No other funds of any kind or amount, however, shall be deposited in or commingled with the Kyat Grant funds in the Project Fund Account opened at the above-mentioned bank for purposes of either of the said Agreements.

2. Kyat Grant funds deposited in the Project Fund Account shall be used solely for the purposes for which those funds have been made available, in conformity with the provisions of the subject Agreement, as amended, and jointly agreed Project Implementation Letters.

3. An initial "advance" of funds equal to three months' needs of the SRUB for meeting expenditures eligible for reimbursement under Parts A and B of the Kyat Grant (but with respect to which reports of actual expenditures cannot immediately be submitted for reimbursement under paragraph 4 below), may, however, be withdrawn from the Project Fund Account and deposited in the SRUB's consolidated fund for such use. Prior to making this withdrawal, the SRUB agrees to prepare and furnish to AID/Burma, not less than ten work days before making the withdrawal from the Account, a schedule showing the SRUB's best estimate of three months' needs for projected SRUB expenditures eligible for reimbursement under Parts A and B of the Kyat Grant. The schedule should provide a detailed breakdown of the total project expenditures, by budget line items in accordance with Table 3 (revised) enclosed with Project Implementation Letter No. 10 dated November 8, 1982, with respect to Part A of the Kyat Grant, and Table 1 of this Project Implementation Letter with respect to Part B of the Kyat Grant. The beginning and ending dates of the three-month period or periods in question should be stated in the schedule, and the schedule should include a certification (or certifications) by a responsible SRUB official (or officials) that the detailed amounts shown in the schedule represent the SRUB's best estimates of projected expenditures eligible for reimbursement under the Kyat Grant for the three-month period (or periods) in question.

4. Following, or in addition to, the withdrawal from the Project Fund Account for the three months' advance under paragraph 3 above, additional withdrawals may be made from the Project Fund Account based on reports of actual expenditures eligible for reimbursement under Parts A and B of the Kyat Grant. Such reports of actual expenditures may be prepared for the purpose of supporting withdrawals from the Project Fund Account as frequently as the SRUB may desire. Each Report of Expenditure prepared for this purpose shall:

(a) be furnished to AID/Burma not less than ten work days prior to the date of the withdrawal from the Project Fund Account,

(b) provide a detailed breakdown of the expenditures eligible for reimbursement under the Kyat Grant, based on the budget line items shown in the two tables referred to in paragraph 3 above,

(c) show the beginning and ending dates of the period or periods covered by the expenditures included in the report, and

(d) include a certification or certifications by a responsible SRUB official or officials that (i) the expenditures shown in the Report represent expenditures that are eligible for reimbursement under the Kyat Grant, in conformity with the provisions of the Project Grant Agreement.

as amended and Project Implementation Letters issued under that Agreement, and (ii) reimbursement has not previously been received from A.I.D. or from any other donor, and is not eligible to be received from any other donor, for any of the amounts claimed by the Report for reimbursement under the Kyat Grant.

5. Withdrawals from the Project Fund Account on the basis of Reports of Expenditure conforming to the requirements of paragraph 4 above may continue to be made until such time as the total amounts withdrawn from the Account for purposes of Parts A and B of the Kyat Grant based on such Reports, plus the amounts of the three-month advance withdrawn from the Account under paragraph 3 above, for purposes of those two parts of the Kyat Grant, plus any amount of Part A of the Kyat Grant that may have been disbursed prior to establishment of the Project Fund Account, equal the total amounts, respectively, of Parts A and B of the Kyat Grant, namely kyat 9,498,000 and kyat 7,748,000. Thereafter, the SRUB will continue to submit Reports of Expenditures conforming to the requirements of paragraph 4, on a "no-withdrawal" basis, until such time as cumulative expenditures eligible for reimbursement based on all Reports of Expenditures prepared and furnished to AID/Burma equal the total amount of each of the said two Parts of the Kyat Grant, in order to liquidate the outstanding advance. Reports of Expenditures showing cumulative expenditures eligible for reimbursement under Parts A and B of the Kyat Grant equal to the total amounts of those two parts of the Kyat Grant must be furnished to AID/Burma not later than nine (9) months following the Project Assistance Completion Date specified in Section 3.3 of the Project Agreement, or such other period as AID agrees to in writing.

6. No withdrawal, for any advance or for reimbursement of expenditures or otherwise, shall be made from the Project Fund Account out of or for purposes of part C of the Kyat Grant until such time as the provisions of paragraphs 3 through 5 above are made applicable to part C of the Kyat Grant by jointly agreed Project Implementation Letter and any applicable mutually agreed condition precedent to such withdrawals have been satisfied.

7. Copies of the periodic bank statements prepared by the Union of Burma Bank for the Project Fund Account, detailing individual deposits and withdrawals and showing the balances in the Account, will be furnished regularly to AID/Burma (not less frequently than quarterly).

8. AID and its authorized representatives will be provided the opportunity, at all reasonable times, in accordance with section B.5 (c) of Annex 2 of the Project Grant Agreement, to review (a) the Project Fund Account at the Union of Burma Bank and (b) the SRUB's books and records supporting the information shown on Reports of Expenditures furnished to AID/Burma in accordance with the provisions of this Project Implementation Letter and those showing the utilization of goods and services financed in whole or in part by the Kyat Grant.

9. The SRUB agrees to redeposit into the Project Fund Account any amount or amounts withdrawn from that Account that A.I.D. or its authorized

representatives may determine have been withdrawn for expenditures that are ineligible for reimbursement under the Kyat Grant, or for which sufficient information to support the withdrawal was not furnished to AID/Burma in conformity with the requirements of this Project Implementation Letter. The SRUB agrees to make any such redeposit into the Project Fund Account within thirty (30) days after receipt of a request therefor from AID or its authorized representative. Funds redeposited into the Account may thereafter be used for purposes of that part of the Kyat Grant with respect to which the redeposit is related, but subject to all governing provisions (including Project Assistance Completion Date) of the Project Grant Agreement and Project Implementation Letters issued thereunder. The amount of any Kyat Grant funds withdrawn from the Project Fund Account for which Reports of Expenditure conforming to the requirements of this Project Implementation Letter have not been furnished to AID/Burma by the end of the nine month period following the applicable Project Assistance Completion Dates (in respect of Parts A and B of the Kyat Grant, the PACD specified in Section 3.3 of the project grant Agreement, and in respect of Part C of the Kyat Grant the separate PACD to be determined in accordance with the provision of said section 3.3) shall also be redeposited to the Project Fund Account.

10. Any balance of funds remaining in the Project Fund Account at the conclusion of the Project, and any funds redeposited to that Account after the conclusion of the Project, shall be used for such development purposes in the health sector of Burma as the parties thereafter may agree upon in writing. If the parties are unable to so agree upon specific uses for any balance of funds remaining in the Account at the conclusion of the Project, and any funds redeposited to that Account after the conclusion of the Project, the funds shall revert to and be paid to AID within thirty (30) days after a request therefor is submitted to the SRUB. The provisions of this paragraph 10 shall apply to Part C of the Kyat Grant, however, commencing at the time that agreement is reached on the specific activities, facilities, and costs to be financed under that part of the Kyat Grant, in accordance with section I-C of this Project Implementation Letter, or, if no agreement is reached within the period of time specified in that section I-C to proceed with the Primary Health Care II Project, upon the failure of the parties to agree upon other specific uses for all or any part of Part C Kyat Grant funds, as stated in the said section I-C.

11. In accordance with section B.5 of Annex 2 to the Project Grant Agreement, the SRUB agrees to furnish AID with such information and reports relating to the carrying out of the activities financed under the Kyat Grant as AID may reasonably request.

If you agree with the above implementation arrangements, please so indicate by countersigning below.

Sincerely yours,

David N. Merrill
AID Representative

U Kyaw Myint
Director General
Budget Department
Ministry of Planning and Finance

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Annex E
Exhibit 4

Ministry of Planning and Finance
BUDGET DEPARTMENT
Ba-7/1 (82-83)
Date: 25-1-83.

Subject: Deposit to Project Fund Account (AID)

Dear U Mg Mg Than,

Kindly accept deposit of K. 129007694.55 (Kyats One hundred twenty nine million seven thousand six hundred ninety four and 55/100 only) to Project Fund Account (AID) for which Cheque No. 01005900 dated 12-1-1983 for the said sum issued by the United States Disbursing Office and received in this Department on 25-1-1983 is enclosed herewith.

Kyaw Kyint
(Kyaw Kyint) 25/1/83
Director General.

Chief Accountant
Union of Burma Bank.

- c.c. (1) AID Representative,
American Embassy,
Rangoon, Burma.
(2) Director General,
Foreign Economic Relations
Department.

PROJECT COMMODITY LISTS

Item No.	Description	Quantity	Unit
<u>CHW Kits (including Snake Bite Kit)</u>			
1.	Soap, toilet 113g bar unwrapped	12	bar
2.	Antibiotic dermatological ointment, tube of 20g	6	tube
3.	Acetylsalicylic Acid, tab 300mg scored tin of 1000	4	tin
4.	Antibiotic Ophthalmic Ointment, tube of 5g	12	tube
5.	Ferrous Sulfate + Folic Acid tabs, tin of 1000	2	tin
6.	Lindane-Gamma Benzene Hexachloride BP Conc 500ml	1	tin
7.	Gentian Violet Powder, Medicinal BP Botl of 25g	1	botl
8.	Iodine Tincture, BP botl of 30ml	2	botl
9.	Multivitamin chewable tabs, tin of 1000	4	tin
10.	Piperazine tabs, BP 500mg scored tin of 1000	1	tin
11.	Salts, Oral Rehydration powder for 1 litre	200	pkt
12.	Phenoxymethyl penicillin, tabs BP 250mg botl of 1000	2	botl
13.	Plastic adhesive, zinc oxide 25mm x 1m roll	3	roll
14.	Bandage, gauze non-sterile 50mm x 9m (2"x10yds)	12	roll
15.	Bandage, gauze non-sterile 75mm x 9m (3"x10yds)	12	roll
16.	Cotton, wool absorbent non-sterile 100g	2	roll
17.	Basin, Kidney 475 ml (16 oz) SS	1	each
18.	Basin, wash shallow 4 litre autoclavable polyprop	1	each
19.	Thermometer, clinical oral dual Cels/Fahr scale	4	each
20.	Forceps, dressing spring-type 150 mm SS	1	each
21.	Scissors, surgical straight 140mm S/B SS	1	each
22.	Box with cover, 228 x 178 x 72 mm plastic	1	each

Estimated cost \$55.00 each

PLUS One each Snake Bite Kit and Booklet

Item No.	Description	Quantity	Unit
<u>MCH Kits for Auxiliary Midwives, Midwives and Lady Health Visitors</u>			
1.	Sterilizer, instrument 222 x 82 x 41 mm SS	1	each
2.	Basin, Kidney 825 ml (28 oz) SS	1	each
3.	Bowl, sponge 600 ml SS	1	each
4.	Bowl, sponge SS set of 2 resting closely	1	set
5.	Cup, solution 180 ml SS	1	each
6.	Irrigator, 1.5 litre SS	1	each
7.	Catheter, tracheal delee open-tip funnel end 16 FR	1	each
8.	Catheter, urethral relation solid-tip one-eye 10 FR	1	each
9.	Catheter, urethral relation solid-tip one-eye 12 FR	1	each
10.	Connector, 3-in-1 for 6 to 8mm tubing nylon	1	each
11.	Bottle, round screw-cap 240 ml polyethylene	1	each
12.	Gloves, surgeon's latex size 6 1/2"	3	pair
13.	Sheeting, plastic clear vinyl 910 mm wide	2	mtr
14.	Tube, rectal one-eye funnel-end 22 FR 500mm rubber	1	each
15.	Tubing, latex rubber for irrigator 1.5m length	1	length
16.	Bottle, dropping 10 ml amber glass	1	each
17.	Thermometer, clinical oral dual Cels/Fahr scale	4	each
18.	Brush, hand surgeon nylon bristle	1	each
19.	Cotton, wool absorbent non-sterile 100 gm	2	roll
20.	Gauze, pad sterile 12 ply 76 x 76 mm square	20	each
21.	Lamp, alcohol with screw cap 60 ml metal	1	each
22.	Soap, toilet 113g bar unwrapped	12	bar
23.	Scale, spring baby 10 kg 100 gm graduations	1	each
24.	Tape measure, 1.5 m/60" vinyl coated fibre glass	1	each
25.	Urinalysis outfit, (albumin) test tubes/botl/clamp	1	set
26.	Stethoscope, foetal pinard monaural	1	each
27.	Forceps, dressing spring-type 150 mm SS	1	each
28.	Forceps, hemostat straight Kelly 140mm SS	2	each
29.	Forceps, sterilizer (utility) 200 mm Vaughn CRM	1	each
30.	Scissors, surgical straight 140mm S/B SS	1	each
31.	Scissors, surgical straight 140mm B/B SS	1	each
32.	Ergometrine Maleate, tab BP 0.2 mg botl of 100	2	botl

Estimated cost \$41.15 each.

PLUS ONE Snake Bite Kit and Booklet

Item No.	Description	Quantity	Unit
<u>TRADITIONAL BIRTH ATTENDANT KIT</u>			
1.	Forceps sterilizer (Utility), 200 mm Vaughn CRM	1	
2.	Soap box, plastic 2-piece hinged plastic	1	
3.	Towel, Huck 430 x 500 mm	2	
4.	Pouch w/drawstring, 210 x 290 mm long 8-gauge PVC plastic	1	
5.	Box, metal 165x90x27 mm: For minor surgery items	1	
6.	Gentian violet powder, medicinal bottle of 25G	1	
7.	Bottle, dropping 10 ml amber glass	1	
8.	Blades, Safety Razor Double-edge pack of 5	1	
9.	Nail Clippers, (must be special-ordered)	1	
10.	Portable Infant Scale	1	

Estimated cost \$20.00 each.

Item No.	Description	Quantity	Unit
<u>SUPPLIES & EQUIPMENT FOR RURAL HEALTH CENTERS</u>			
1.	Scale,physician adult metric 140kgs x 100G	1	each
2.	Scale,infant metric 16kgs x 20G	1	"
3.	Sterilizer,instr. boiling type 320x170x100 mm fuel	1	"
4.	Stove,kerosene single burner, pressure type	1	"
5.	Basin,kidney 475 ml (16oz) stainless steel	2	"
6.	" " 825 ml (28oz) " "	2	"
7.	Basin,solution deep approx 6 litre SS	2	"
8.	Bowl,sponge, 600 ml stainless steel	4	"
9.	Cup, solution, 180ml stainless steel	2	"
10.	Irrigator,1.5 ltr. stainless steel	1	"
11.	Jar,desssing w/cover 2.13 lit. SS	2	"
12.	Measure,graduated w/handle 500ml/1 pint SS	1	"
13.	Tray,inst/dressing w/cover 310x195x63mm SS	1	"
14.	Tray,instrument shallow 480x330x19 mm SS	1	"
15.	Catheter,urethral nelaton solid tip one-eye 14FT	2	"
16.	Connector,3-in-1 for 6 - 8 mm tubing nylon	2	"
17.	Gloves,surgeon's latex size 7	3	pairs
18.	Sheeting,plastic clear vinyl 910mm wide	2	mtr.
19.	Shield,nipple glass shell rubber nipple	5	each
20.	Syringe,ear & ulcer conical rubber tip 100 ml	1	"
21.	Syringe,rectal infant rubber bulb hard tip 30ml	2	"
22.	Tube,rectal one-eye funnel-end 20FR 500mm rubber	2	"
23.	Tube,rectal one-eye funnel-end 24FR 500mm rubber	1	"
24.	Tubing,latex rubber for Irrigator 1.5 mm length	2	lgth.
25.	Dropper,medicine curved tip ungraduated	6	each

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Item No.	Description	Quantity	Unit
26.	Thermometer, clinical oral 35 to 42 ^o C	3	each
27.	Thermometer, clinical rectal 35 to 42 ^o C	3	"
28.	Brush, hand surgeon's white nylon bristles	2	"
29.	Lancet (Hagedorn suture needle)	6	"
30.	Stone, sharpening oil Arkansas 50x19x6.3mm	1	"
31.	Suture, cotton white non-sterile 00 USP 91M	1	SPL
32.	Tape-measure, 1.5M/60" Vinyl-coated fibre glass	1	"
33.	Tourniquet, web heavy olive drap 30 x 1066 mm	1	"
34.	Urinary-test-set complete	1	set
35.	Urinometer, squibb complete shotweighted	1	set
36.	Tongue-depressor, 165 mm. metal	3	each
37.	Pelvimeter collyer, external grad. CMS/inches	1	"
38.	Sphygmomanometer, mercurial 300 desk type	1	"
39.	Stethoscope, ford-type binaural complete	1	"
40.	Stethoscope, foetal, pinard monaural	1	"
41.	Catheter, urethral female 12FT metal	1	"
42.	Forceps, dressing spring type 150 mm SS	2	"
43.	Forceps, hemostat straight kelly 140 mm SS	2	"
44.	Forceps, sponge-holding straight 225mm SS	1	"
45.	Forceps, sterilizer (utility) 200mm Vaughn CRM	1	"
46.	Forceps, uterine vulsellum straight Jacobs 250mm	1	"
47.	Knife, handle surgical for minor surgery No.3	1	"
48.	Knife, blade surgical for minor surgery No.10 pkt 5	1	pkt
49.	Knife, blade surgical for minor surgery No.11 pkt 5	1	"
50.	Knife, blade surgical for minor surgery No.12 pkt 5	1	"

Item No.	Description	Quantity	Unit
51.	Needle, hypo 0.70 x 38mm/22G x 1½" luer box of 12	1	box
52.	Needle, hypo 0.55 x 19mm/24G x 3/4" luer box of 12	2	"
53.	Needle, hypo 0.90 x 38mm/20Gx1½" luer box of 12	1	"
54.	Needle, suture 3/8 circ. TRI PT pkt of 6 asst.	1	pkt
55.	Scissors, bandage angular lister 182 mm SS	1	each
56.	Scissors, gauze str. 215mm sharp/blunt point SS	1	"
57.	Scissors, surgical straight 140mm S/B SS	2	"
58.	Speculum, vaginal BI-Valve Graves small SS	1	"
59.	Syringe, hypo 2 ml, luer-glass loc tip	3	"
60.	Syringe, hypo 5 ml, luer-glass loc tip	2	"
61.	Syringe, hypo 10 ml, luer-glass loc tip	2	"
62.	Clamp, tubing regulating Hoffmann, 13x19mm	2	"
63.	Hemoglobinometer-set, Sahli-type, complete	1	set
64.	Pipette, Sahli 0.02ml for Hemoglobinometer	2	each
65.	Measuring tube, sq. (14.5G HB) for Hemoglobinometer	1	"

Estimated cost - \$304.33 each

AUXILIARY MIDWIFE MEDICINE KIT

	Unit
1. Scale (Salter)	1
2. Ferrous sulfate/1000s	10
3. Ergometrine maleate	2
4. Vit A cap high potency 200,000 IV/100	1
5. ORS powder/1 L	100
6. ASA 300mg/1000	3
7. Antibiotic, ophthalmic oint 1%/5 gm tube	10
8. gentian violet powder, medicinal/25 gm	1
9. Scale, bathroom metric/ avoirdupois 120 kg/280 lb	1

Appropriate cost \$ 109.32

Item No.	Description	Quantity	Unit
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SUPPLIES & EQUIPMENT FOR RURAL HEALTH SUB-CENTERS

1.	Scale bathroom metric/Avoirdupois 120 kg/280 lb	1	each
2.	Basin, kidney 475ml (16 oz) stainless steel	2	"
3.	Bowl, sponge, 600 ml SS	2	"
4.	Jar, dressing w/cover, 2.13 ltr SS	2	"
5.	Measure, graduate w/handle 500 ml 1 pt SS	1	"
6.	Tray, instrument/dressing w/cover, 310 x 195 x 63 mm SS	1	"
7.	Thermometer clinical oral 35 to 42°C	3	"
8.	Tape measure, 1.5m/60" vinyl coated fibre glass	1	"
9.	Tourniquet, fabric web heavy olive drap 38 x 1066 mm	1	"
10.	Urinary test set, complete	1	set
11.	Tongue depressor, 165 mm, metal	1	each
12.	Sphygmomanometer aneroid, 300 mm w/bandage cuff	1	"
13.	Stethoscope, foetal pinard monaural	1	"
14.	Stethoscope, ford type binaural complete	1	"
15.	Scissors, surgical str. 140 mm S/B SS	1	"
16.	Syringe, type hypo 2 ml luer glass	1	"
17.	Syringe, hypo 10 ml, luer glass	1	"
18.	Needle, hypo, 0.70 x 38 mm 22GX1-1/2" luer box of 12	2	box

Estimated cost \$50.42

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Item No.	Description	Quantity	Unit
<u>DDS Sets for Rural Health Sub-Centres, Rural Health Centres, Urban Health Centres, MCH Centres and School Health Teams</u>			
1.	Soap, toilet 113 g bar unwrapped	12	bar
2.	Antibiotic dermatological ointment, tube of 20g	7	tube
3.	Acetylsalicylic Acid, tab 300mg scored tin of 1000	4	tin
4.	Antibiotic ophthalmic ointment, tube of 5g	12	tube
5.	Ferrous Sulphate + Folic Acid tabs, tin of 1000	2	tin
6.	Lindane-Gamma Benzene Hexachloride, BP Conc 500 ml	1	tin
7.	Gentian Violet Powder, Medicinal BP botl of 25g	1	botl
8.	Iodine Tincture, BP botl of 30 ml	2	botl
9.	Multivitamin chewable tabs, tin of 1000	4	tin
10.	Piperazine tabs, BP 500 mg scored tin of 1000	1	tin
11.	Salts, Oral Rehydration powder for 1 litre	200	pkt
12.	Phenoxymethyl penicillin tabs BP, 250 mg botl of 1000	2	botl
13.	Metronidazole tabs, BP 250 mg tin of 1000	1	tin

Estimated cost \$78.95 each

PLUS ONE Booklet each

PROJECT IMPLEMENTATION BAR CHART

1983

1984
Year 1

1985
Year 2

1986
Year 3

1987
Year 4

- 11. Biostatistics One (1985)
- 12. Computer Science One (1985)
- B. Short Term
 - 1. Educational Techniques (6) 24 pm(1983/84/85)
 - 2. Health Statistics Demography One (1984)
 - 3. Maternal Child Health (6) 24 pm(1984/85/86)
 - 4. Health Planning (3) 18 pm(1984/85/86)
 - 5. Environmental Health - One 4 pm (1984)
 - 6. Observation Tours 12 pm(1983/84/85)
 - 7. Management Training - One 6 pm
 - 8. Training of Trainers One 4 pm
 - 9. Other Short Term

Activity	1983	1984	1985	1986	1987
11. Biostatistics One (1985)					→
12. Computer Science One (1985)					
B. Short Term					
1. Educational Techniques (6) 24 pm(1983/84/85)		=====	=====	=====	
2. Health Statistics Demography One (1984)			=====		
3. Maternal Child Health (6) 24 pm(1984/85/86)		=====	=====	=====	
4. Health Planning (3) 18 pm(1984/85/86)			=====		→
5. Environmental Health - One 4 pm (1984)			=====		
6. Observation Tours 12 pm(1983/84/85)		=====	=====	=====	
7. Management Training - One 6 pm		=====			
8. Training of Trainers One 4 pm		=====			
9. Other Short Term			=====	=====	

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1983

1984
Year 1

1985
Year 2

1986
Year 3

1987
Year 4

III Commodities

A. Develop Specifications

B. Prepare IFB

C. Procurement

1. AMW Kits

2. AMW Drug Kits

3. CHW Kits

4. TBA Kits

5. Training Equipment

6. Printing Materials

7. Scales

8. Vehicles

9. RHC Equip.

10. Sub-center Equip.

11. Station Hospital Equip.

	1983	1984 Year 1	1985 Year 2	1986 Year 3	1987 Year 4
A. Develop Specifications					
B. Prepare IFB					
C. Procurement					
1. AMW Kits					
2. AMW Drug Kits					
3. CHW Kits					
4. TBA Kits					
5. Training Equipment					
6. Printing Materials					
7. Scales					
8. Vehicles					
9. RHC Equip.					
10. Sub-center Equip.					
11. Station Hospital Equip.					

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	1983		1984 Year 1			1985 Year 2		1986 Year 3			1987 Year 4	
12. Training Equip./ A-V & Video												
13. Contraceptives												
14. Clinic Equip.												
15. Medical kits												
16. Paper, Ink, Stationary												
IV <u>Evaluation</u>												
A. Internal												
B. External												

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1983

1984
YEAR

1

1985
YEAR

2

1986
YEAR

3

1987
YEAR

4

V. Training

1. Initial Revision of Training Materials

2. AMW/CHW/TBA Training (1/3 of Total)

3. Evaluation and Revision of Training Materials

4. AMW/CHW/TBA Training (1/3 of total)

5. Evaluation and Revision of Training Materials

6. AMW/CHW/TBA Training (1/3 of total)

7. Retraining of Deployed VHW's

	1983	1984 YEAR	1985 YEAR	1986 YEAR	1987 YEAR
1. Initial Revision of Training Materials					
2. AMW/CHW/TBA Training (1/3 of Total)					
3. Evaluation and Revision of Training Materials					
4. AMW/CHW/TBA Training (1/3 of total)					
5. Evaluation and Revision of Training Materials					
6. AMW/CHW/TBA Training (1/3 of total)					
7. Retraining of Deployed VHW's					

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Annex H

COUNTRY CHECK LIST/STATUTORY CHECK LIST

COUNTRY CHECKLIST / STATUTORY CHECKLIST

I. Country Checklist

A. General Criteria for Country Eligibility

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

Yes, to the first question. No, to the second.

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

No.

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

Yes.

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

No, so far as is known.

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

No.

6. FAA Sec. 620(a), 620(f); FY 79 App. Act, Sec. 198, 114 and 606. Is recipient country a Communist country? Will assistance be provided to the Socialist Republic of Vietnam, Cambodia, Laos, Cuba, Uganda, Mozambique, or Angola?

No.

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

No.

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

No.

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

An OPIC agreement with Burma is not possible at this time.

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

N/A

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

No.

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

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

Yes.

2. Economic Support Fund Country Criteria

N/A

II. Project Checklist

A. General Criteria for Project

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

(a) The project was included in the 1983 Congressional Presentation.

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, Project Paper reflects the necessary plans and contains the cost estimates.

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

No action required.

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

N/A

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

N/A

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

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

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

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

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

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

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

The SRUB and local communities will contribute more than 25% of project costs; US owned excess foreign currency will be utilized for part of the local costs.

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

Yes, Kyat 34,000,000 out of the total Kyat Grant made under Mondale-Poage authority of PL 480 in January 1983 has been earmarked for use in financing part of the local costs of the project. The total amount of the Kyat Grant has been deposited in a Project Fund Account for disbursement in accordance with procedures agreed upon in writing between the two Governments. See Annex E.

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

Yes.

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

N/A

B. Funding Criteria for Project

1. Development Assistance Project Criteria

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

- (a) Purpose of the project is to extend health services to the village level and to involve a wide segment of the poor in the project on a sustained basis.
- (b) N/A
- (c) Yes
- (d) Yes. See "The Role of Women" in section D, "Social Analysis," of Part III, "Project Analysis," of the Project Paper.
- (e) Yes

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

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

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

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

No, to first question.

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

The GSRUB is not known to be in arrears.

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

No.

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

No.

B. Funding Criteria for Country Eligibility

1. Development Assistance Country Criteria

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

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

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

With the adoption of Family Health Counseling which includes contraceptive service; child spacing, infertility research and mother/baby craft, the project is designed to build motivation for smaller families.

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

Yes.

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

Yes.

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

N/A

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

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

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

Yes.

2. Development Assistance Project Criteria (Loans Only)

N/A

Annex I

PROJECT AUTHORIZATION
AND AMENDMENT

PROJECT AUTHORIZATION

BURMA

Primary Health Care II
Project No. 482-0004

1. Pursuant to Section 104(c) of the Foreign Assistance Act of 1961, as amended, I hereby authorize the Primary Health Care II Project (the "Project") involving planned obligations of not to exceed Ten Million U.S. Dollars (\$10,000,000) in grant funds ("Dollar Grant") over a three year period from the date of authorization, subject to the availability of funds in accordance with the A.I.D. OYB/allotment process, to help in financing foreign exchange costs of the Project.

2. The Project consists of the training, equipping and deploying of approximately 8,000 Community Health Workers (CHWs) and 2,700 Auxiliary Mid-Wives (AMWs), and the training of 12,000 Traditional Birth Attendants (TBAs). A.I.D. will also support advisory services and technical assistance to the Burmese Health Assistants Training School, the Department of Health's Health Information Service, and the new Family Health Counseling Service. Equipment and supplies will be furnished in the form of kits to the CHWs, AMWs and TBAs as well as to the Family Health Counseling Service. A portion of the local currency costs of the Project will be financed by 34,000,000 excess Burmese Kyat which were granted to the Cooperating Country on January 7, 1983 under the authority of Section 104 of P.L. 480.

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

a. Condition Precedent to Execution of Project Agreement

Prior to execution of the Project Agreement, the Cooperating Country must furnish A.I.D. a written request for assistance.

b. Source and Origin of Commodities, Nationality of Suppliers of Commodities and Services

Commodities financed by A.I.D. for the Project under the Dollar Grant shall have their source and origin in the United States except as A.I.D. may otherwise agree in writing. Except for ocean shipping, the suppliers of commodities or services financed by A.I.D. under the Dollar Grant shall have the United States as their place of nationality, except as A.I.D. may otherwise agree in writing.

Ocean shipping financed by A.I.D. for the Project under the Dollar Grant shall, except as A.I.D. may otherwise agree in writing, be financed on flag vessels of the United States. Training financed under the Dollar Grant may be undertaken in the United States or in third countries in accordance with the provisions of A.I.D. Handbook 10.

c. Condition Precedent to Disbursement for Medical Supplies and Equipment

Prior to any disbursement, or the issuance of any commitment documents under the Project Agreement, to finance medical supplies and equipment, the Cooperating Country shall furnish, in form and substance satisfactory to A.I.D., a plan for ensuring that imported Project commodities are cleared through customs in timely fashion, and thereafter distributed in timely fashion to station hospitals, rural health centers, sub-centers, family health counseling clinics, and voluntary health workers under the Project.

4. Waivers

Based upon the justification and findings set forth in Annex J of the Project Paper, I hereby:

a. Approve a waiver of source and origin requirements from A.I.D. Geographic Code 000 (U.S. only) to Code 935 (Free World) for the procurement of medical supplies and equipment to be supplied by UNICEF in the amount of approximately \$2.2 million and certify that exclusion of procurement from Free World countries other than the Cooperating Country would seriously impede attainment of U.S. foreign policy objectives and objectives of the foreign assistance program; and

b. Authorize noncompetitive negotiation pursuant to AIDPR 7-3.101-50(b)(7) and (c)(2) to procure such medical supplies and equipment from UNICEF for the Project and

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determine that procurement of these commodities from any other source would impair foreign assistance objectives and would be inconsistent with fulfillment of the foreign assistance program.

Clearances:	Date	Initial
Herbert E. Morris, GC/Asia	<u>5/27/83</u>	<u>HEM</u>
G. R. Van Raalte, Asia/PD	<u>5/24/83</u>	<u>K</u>
Larry Smucker, Asia/DP	<u>5/23/83</u>	<u>LS</u>
Allen C. Hankins, Asia/TR	<u>5/23/83</u>	<u>ACH</u>
Dennis Barrett, Asia/PTB	<u>5/23/83</u>	<u>DB</u>

Signature Charles W. Greenleaf
Charles W. Greenleaf
Assistant Administrator for Asia

May 26 1983
Date

SA
GC/Asia:SAllen:hp:5/23/83

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

PROJECT AUTHORIZATION

AMENDMENT

BURMA

Primary Health Care II
Project No. 482-0004

1. Pursuant to Section 104(c) of the Foreign Assistance Act of 1961, as amended, the Primary Health Care II project for Burma was authorized on May 26, 1983. That authorization is hereby amended to reduce the amount of planned obligations for the project from Ten Million U.S. Dollars (\$10,000,000) to Seven Million, One Hundred Forty Thousand U.S. Dollars (\$7,140,000) and to delete from the authorization the family health counseling component of the project including all references to Family Health Counseling Service and family health counseling clinic.
2. The authorization cited above remains in force except as hereby amended.

Clearances:	Date	Initial
Stephen R. Tisa, GC/Asia	6/27/83	ST
G.R. Van Raalte, Asia/PD	6/27/83	VR
Larry Smucker, Asia/DP	6/27/83	LS
Dennis Barrett, Asia/PTB	6/27/83	DB
Allen C. Hankins, Asia/TR	23 June 83	ACH

Signature Charles W. Greenleaf
 Charles W. Greenleaf
 Assistant Administrator for Asia

June 28, 1983
 Date

GC/Asia:STisa:hp:6/20/83

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ANNEX J

WAIVERS
&
NON-COMPETITIVE PROCUREMENT

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WAIVERS

A. Source/Origin Waiver and Justification for Non-Competitive Procurement

The Project Paper proposes the continuation of the previously approved practice in PHC I of the procurement of equipment/drug kits for the volunteer health workers from UNICEF/Copenhagen. The reasons are as follows:

1. These kits have been supplied by UNICEF since the inception of the program four years ago and are familiar to trainers and workers.
2. Volunteer Health Workers pre-service training is based on the contents of these kits as is in-service training.
3. Major changes in kit contents would disrupt established training curricula.
4. The SRUB Department of Health is satisfied with the existing kits.
5. Any alterations in kit contents, based only on the desire for U.S. source/origin of items, would be resisted by the DOH.
6. UNICEF keeps stocks of kit items in Copenhagen and can fill orders rapidly.
7. Because of mass purchasing, kit costs are estimated to be 50% to 75% less than similar U.S. purchases.
8. Transportation from Copenhagen to Rangoon is more rapid and frequent than from the U.S. and transshipment is often not necessary.

To utilize UNICEF as a source for these kits, it is necessary to obtain approval for non-competitive procurement and a source/origin waiver permitting purchase from Code 935 sources. The country of origin of each kit item will be determined by AID and UNICEF and non-935 country origin items will be excluded and substituted. U.S. items will be placed in the kits in Burma. Experience with kits procured under PHC I found three such items. It is estimated that purchases from UNICEF will approximately be \$2.2 million.

AID/Rangoon proposes to rely on the established UNICEF tests for efficiency and other measures of quality control for pharmaceuticals.

B. Transportation/Shipping

An appropriate waiver is requested to allow the use of non-U.S. or host country vessels to transport AID-financed commodities purchased from UNICEF where U.S. flag vessels are not available.

Annex K

BURMESE REQUEST FOR ASSISTANCE



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

D.O. No.

Dated, the August 12, 19 83.

Mr. Charles D. Ward,
AID Representative,
American Embassy,
Rangoon.

Dear Mr. Ward,

With reference to Mr. Nelson's letter of June 1, 1983 and your letters of July 8 and July 21, 1983, concerning the contributions by the United States Agency for International Development for the Primary Health Care II Project, I have the pleasure to inform you that the said project has now been approved by our authorities.

Accordingly, I should like to hereby make a formal request on behalf of the Government of the Socialist Republic of the Union of Burma for a grant of US\$ 7.14 million for the Primary Health Care II Project out of which US\$ 5.1 million is to be obligated immediately upon signing of the Project Grant Agreement. The remainder of the grant is to be obligated in the following two years.

In addition to the dollar grant, 34 million kyats out of the kyat Grant under PL 480 signed on January 7, 1983, will be utilized to finance the local currency costs of the Primary Health Care II Project.

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

Yours sincerely,

(Thain Kyint)
Director-General

Annex L

DOCUMENTS REVIEWED

Documents Reviewed (During Project Paper Formulation)

1. 1°HC and BHSP, Burma 1977-82 (1976 Draft. Rev. March 1978)
(Country Health Program, Burma)
2. CHW Manual (in Burmese)
3. Training Curriculum Schedule, CHW
4. LHV and VHW Refresher Course Manual
5. Nutrition Curriculum
6. Basic AMW Manual
7. Rainbow Card
8. Training of State and Division Training Teams
Training Objectives and Teaching/Learning Activities
HATS, Aung Sanmye, Rangoon, Burma 1980
9. Task-oriented Curriculum for PHS Grade 2
HATS, 5/81
10. BH Worker Training Manual, White 1-8-81/16-9-81 (6 weeks' course)
11. BH Worker Training Manual, Yellow
12. Report of the Prenatal Mortality and Low Birth Weight Study Project, Burma
Searo Intercountry Collaborative Project, WHO
Ed. Tin U and T.O. Daw Myint
Dept. Med Educ., Min. of Health, Rangoon, Burma 1981
Ref: SEA/ICP/MCH/OIO
13. Peoples' Health Plan, Burma 1982-6
Community Health Care Project Proposal
Dept. Health, MOH Rangoon
Doc. No. FP(CHC) CHP II (10) 21 April 1981

14. Township Profile, KYAUKPADAUNG
Dr. Tin H Toot, TMO (2)
KYAUKPADAUNG
15. Health Info. Booklet 1981 DOH, MOH, Health Info.
Svces. Burma 9/81
16. Hospital Impt. Report 1979 MOH
HIS. DOH Rangoon
17. Stat. Rept. 1979 HIS DOH MOH
Rural Hosp. Admin. Svces. 30-9-80
18. Report to the Pyithu Hluttaw on the Finance,
Economic and Social Care of the SRUB 1981-82
Minister of Planning & Finance 1981
19. 1979/Feb. Country Profile Burma
20. AMW Curriculum
21. CHW manual Translation to English
22. Health and Demographic Info Booklet for States and Divisions
H25 23 June 82 (Khin Maung Thwin)
Senior Health Statistician
23. Primary Health Care Evaluation, Midterm Report, USAID Burma, 4/82
24. UNICEF Plan of Operation 1982-86 Devel. of Basic Health Services
for Children and Mothers in Burma, Rangoon
25. 2nd Peoples Health Plan (1982-6 FP(CHC) (CHP II) (10) 21/4/81
26. Study of Village Health Attitudes
Dr. Aung Tun Thet, Inst. of Econ. Rangoon 1981
27. Burma: Priorities for Continued Growth
7 May 82 World Bank
28. Annual Report 1981 and Program of Work, 1982-3, Vector-borne disease
control project Feb 82, DOH, Rangoon.

29. A.I.D. Policy Paper, Health Assistance
30. A.I.D. Policy Paper, Population Assistance
31. A.I.D. Policy Paper, Nutrition
32. A.I.D. Policy Paper, Recurrent Costs
33. A.I.D. / Burma, Mid-Term Evaluation of Primary Health Care I, May 1982.

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