PD-AAQ-436

AGENCY FOR INTERNATIONAL DEVELOPMENT

PROJECT DATA SHEET

1. TRANSACTION CODE ISN: 37656
A = Add
C = Change
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Amendment Number

DOCUMENT CODE 3

2. COUNTRY/ENTITY
Inter-Regional

3. PROJECT NUMBER
936-5927

4. BUREAU/OFFICE
ST/Health 36

P.P.

5. PROJECT TITLE (maximum 40 characters)
Technology for Primary Health Care

6. PROJECT ASSISTANCE COMPLETION DATE (PACD)
MM DD YY

7. ESTIMATED DATE OF OBLIGATION
(Under 'B.' below, enter 1, 2, 3, or 4)
A. Initial FY 83 B. Quarter 2 C. Final FY 87

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	2,000	-	2,000	19,000		19,000
(Grant)	(2,000)	(-)	(2,000)	(19,000)	( )	(19,000
(Loan)	( )	( )	( )	( )	( )	(
Other U.S. 1.						
Other U.S. 2.						
Host Country						
Other Donor(s)						
TOTALS	2,000	-	2,000	19,000		19,000

9. SCHEDULE OF AID FUNDING ($000)

A. APPROPRIATION	B. PRIMARY PURPOSE CODE	C. PRIMARY TECH. CODE 1. Grant	C. 2. Loan	D. OBLIGATIONS TO DATE 1. Grant	D. 2. Loan	E. AMOUNT APPROVED THIS ACTION 1. Grant	E. 2. Loan	F. LIFE OF PROJECT 1. Grant	F. 2. Loan
(1) HEA	539	510		-	-	19,000		19,000	
(2)									
(3)									
(4)									
TOTALS						19,000		19,000	

10. SECONDARY TECHNICAL CODES (maximum 6 codes of 3 positions each)
540

11. SECONDARY PURPOSE C
519

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

A. Code	BR	PART	TECH				
B. Amount							

13. PROJECT PURPOSE (maximum 480 characters)

The improvement and expansion of PHC services and management capabilities in developing countries through the transfer of selective, proven technologies in disease control and through the provision of PHC management and manpower development technical services for the improvement of design, implementation and evaluation of PHC programs.

14. SCHEDULED EVALUATIONS
Interim MM YY MM YY Final MM YY

15. SOURCE/ORIGIN OF GOODS AND SERVICES
☐ 000 ☐ 941 ☐ Local ☐ Other (Specify)

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

17. APPROVED BY
Signature
Title
Date Signed MM DD YY

18. DATE DOCUMENT RECEI IN AID/W, OR FOR AID/W D MENTS, DATE OF DISTRIBI
MM DD YY

TECHNOLOGY FOR PRIMARY HEALTH CARE (PHC TECH)

Table of Contents

Project Data Sheet

Page

I. Project Summary

II. Project Description 4

A. Background 4

1. A Decade of Experience with Primary Health Care (PHC)

2. Constraints to Achieving Successful PHC Programs and Projects

3. Proposed Response

4. Relationship of Project to A.I.D. Policy and Health Sector Strategy

B. Project Components 5

1. Technology Transfer for Disease Control

(a) Oral Rehydration Therapy (ORT)

(b) Immunization

(c) Additional Disease Control Interventions

(d) Associated Commodities and Supplies

2. Technical Assistance for Management, Training and Project Design and Evaluation 10

(a) Management

(b) Personnel Training and Development

(c) Design and Evaluation

3. Information Services 12

(a) PHC Information Center

(b) Technical Conferences

C. Beneficiaries 13

D. Relationship of Project to Other A.I.D. and Donors' ORT and EPI Efforts 13

III. Implementation 14

A. Roles of Participating Parties
1. USAIDs
2. Regional Bureaus
3. ST/HEA Project Manager
4. External Advisory Group
5. Contractor

B. Project Implementation Schedule

IV. Evaluation 18

A. Performance Critiques

B. Annual Reviews

C. External Evaluations

V. Budget and Financial Plan 24

ANNEXES

A. Log Frame
B. Regional Bureau and Mission Guidance and Support
C. Overview of A.I.D. ORT and EPI Activities

I. PROJECT SUMMARY

The goal of the "Technology for Primary Health Care" (PHC Tech) project is to lower infant, child and maternal morbidity and mortality through the introduction and improved delivery of key disease control technologies, such as, oral rehydration therapy (ORT) and immunizations, in primary health care (PHC).

The PHC Tech project is a 5-year, 19 million dollar, inter-regional effort. In order to achieve the project purpose, a contractor or cooperator will be selected through open competition to provide 1117 person months of technical assistance, a limited amount of selected PHC commodities, technical information services and 8 regional and one inter-regional technical in-training conferences. Although a contractor will serve as the primary technical resource, responsibility for authorizing, managing, and evaluating project activities rests with A.I.D. The PHC Tech Project Manager in S&T/H will be responsible for approval of PHC Tech project funds for specific project activities, and the ongoing monitoring of the contractor's performance in implementing and completing the authorized project activities. In order to assure adequate programmatic and financial management of the project, the project manager will require monthly reports from the contractor. These will include analysis of the actual drawdown of project funds, projected funding requirements for authorized activities, as well as estimated projections of future demand for services to determine the adequacy of S&T/H project funds. Subject to availability of funds, S&T/H will provide a basic level of project services. To meet demand above this level, supplemental funds from participating USAIDs and AID/W bureaus can be added in annual or bi-annual amendments to the contract. Two budgets have been developed. The $19 million includes "Regional transfers" to supplement the $12 million budget which is detailed in Part V of the paper - Budget and Financial Plan. The $12 million budget in Part V describes only the allocation of the $12 million to be provided from S&T/H's budget. This arrangement is somewhat comparable to arrangements under the previous ADSS project.

PHC Tech reflects the priorities outlined in the recent Agency Health Policy and Strategy documents. It focuses on key technological interventions to improve the cost-effectiveness of developing country health programs. The project will build on and incorporate successful and appropriate aspects of the two previous ST/H projects--ADSS and MEDEX which expire in 1983, as well as components of a communicable disease health initiative which was proposed

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* the Contract Office will make the final decision as to whether the project should be implemented as a contract or a cooperative agreement.

for 1982 but was not developed. The project will not duplicate or overlap with the ongoing ST/H PHC-Operations Research Project (PRICOR), as it does not have a research component. This project will also benefit from and utilize the PHC management and training materials currently being developed through ST/H's Health Development Planning and Management (HDPM) project. The PHC Tech project will not provide for the transfer of proven technologies in the area of water supply and sanitation since assistance in this area is currently available through the Water and Sanitation for Health (WASH) project.

Issues raised by USAIDs or AID/W bureaus in response to the PHC Tech PID have been considered in the development of this Project Paper. Details and the resolution of these issues are given in Annex B.

II. Project Description

A. BACKGROUND

1. A Decade of Experience with Primary Health Care (PHC)

Over the past decade, Primary Health Care (PHC) has evolved as a community-based approach to meeting the basic health needs of people in developing countries. Based on the realization that the common health problems of populations in developing countries cannot be met by conventionally organized, hospital-based services, many developing countries have begun to develop PHC systems. The "PHC approach" is characterized byemphasis on (1) the equitable distribution of health resources, (2) community participation, (3) prevention, (4) appropriate technologies and (5) a multi-sectoral approach to improving health status. PHC systems tend to focus on the provision of basic health, nutrition and family planning services by mid-level and community health workers, particularly in underserved areas of LDCs. A.I.D. has supported many PHC projects, gaining a wide range of experience in the design and implementation of alternative approaches to PHC health service delivery, management, and manpower development.

2. Constraints to Achieving Successful PHC Programs and Projects

At the same time that developing countries are designing strategies to achieve the goal of "Health for All by 2000" through the PHC approach, others are questioning whether this goal is attainable given the multiple resource constraints in most developing countries. Thus, increasing emphasis is being given to directing PHC resources towards the prevention and treatment of those diseases responsible for the greatest mortality and morbidity in developing countries and for which proven and efficacious interventions exist.

In many developing countries, 15 percent or more of all infants die before reaching age one, and up to 30 percent die before age five. They die from dehydration as a result of diarrhea, respiratory infections, tetanus, and childhood infectious diseases such as diptheria, measles, and whooping cough. Malnutrition, poor sanitation and housing, and mothers' lack of knowledge exacerbate these childhood health problems.

Worldwide experience in PHC has shown that oral rehydration therapy (ORT) and immunization can be delivered through PHC programs and are particularly effective in reducing mortality and morbidity among infants and children under five. However, there is a substantial gap between the scientifically demonstrated potential of immunization and ORT and the availability of these services in most developing countries. One of the reasons the availability of immunizations and ORT is limited is because the effectiveness of these and other PHC interventions is dependent on other "inputs" into the delivery of PHC, e.g. appropriately trained and supported PHC workers, a well-managed supply and logistics system and adequate and appropriately channeled financial resources. Many PHC systems suffer from inadequate project design, ineffective management (e.g. logistics and information) systems and high recurrent costs. Furthermore, many training programs have not produced health workers with adequate and appropriate skills to effectively implement PHC interventions. This project is an effort to help A.I.D. and host countries improve the delivery of key services and strengthen their institutional capacity to plan, manage, and evaluate PHC programs.

3. Proposed Response

S&T/Health, in collaboration with the Regional and other AID/W Bureaus, has developed a new health project to assist USAIDs and host countries in the improvement of primary health care services through (1) the transfer of selected, proven technologies in disease control, (2) the provision of technical assistance in management, competency-based training, and project design and evaluation, and (3) technical information services, including conferences and workshops.

4. Relationship of Project to A.I.D. Policy and Health Sector Strategy

Consistent with U.S. support for selective PHC, and A.I.D.'s emphasis on the identification and transfer of appropriate, proven technologies for development in all sectors, this project focuses on key areas within PHC programs where the transfer of selected technologies is expected to improve infants' and childrens' chances for survival and future productivity. The project will make available technical experts and information to help promote host country policies which improve the effectiveness, efficiency and long-term viability of health programs. Attention will be given to increasing the role of the private sector in health service delivery. Further, this project will provide resources to improve indigenous institutional capability for the design and management of PHC projects to better assure that developing countries will be able to sustain these programs technically, administratively and financially when external assistance has ended.

B. PROJECT COMPONENTS

This project has both promotive and responsive elements. The primary promotive elements will consist of a world-wide, technology-transfer resource

for USAIDs and AID/W Bureaus to promote the use of oral rehydration therapy, immunizations and other selective disease control technologies in that order of priority. It will also promote improvements in health management and training so that key technologies reach the target populations cost-effectively. It will be responsive to A.I.D. project design and evaluation requirements where other appropriate mechanisms do not exist to meet them. Lastly, the technical information component will both promote technical knowledge about ORT, immunizations and service delivery techniques as well as respond to other specific technical information needs.

1. Technology Transfer for Disease Control

Approximately 400 person months (PM) of technical assistance will be provided over 5 years for the transfer of ORT, immunization and other effective disease control technologies. These transfer technologies have been selected because A.I.D.'s health sector policy and strategy emphasize investments in demonstrated, cost-effective interventions with high potential to reduce morbidity and mortality in developing countries. Technical assistance will be available for short-term, problem oriented assignments up to 90 consecutive days or on an intermittent basis over a longer period (not to exceed 9 months over a 2 year period), when a longer term support relationship is sought for specific PHC program development efforts.

Primary emphasis under the selective disease control component of this project will be on the promotion of ORT and immunization activities. Mission responses to the PID cable indicated strong agreement that ORT and immunization represent two particularly effective health interventions in developing countries for reducing the mortality and morbidity of infants and children. However, several Missions expressed a need for assistance with other diseases which had a high priority in their specific countries (e.g. malaria). Therefore, the project will also be able to provide assistance for other effective disease control interventions where criteria for need can be met. This should be based on an assessment of the following in each country:

- epidemiology: i.e., causation, nature, magnitude and severity of health problems affecting (1) infant and child mortality and (2) labor productivity;
- technology: i.e., availability of appropriate diagnostic, prevention and treatment technologies to address these health problems;
- economics: i.e., investment and recurrent cost requirements of the services; macroeconomic constraints, ability and willingness to finance, user-financing mechanisms; and
- political, managerial, social, infrastructure and administrative feasibility of proposed interventions.

a. Oral Rehydration Therapy (ORT)

Diarrhea is a major cause of death in children under five in developing countries. Acute diarrheas may be caused by bacteria, viruses or parasites, the most significant being rotavirus, escherichia coli, shigella, salmonella, and cholera. Mortality from diarrheal disease is usually due to dehydration,

a severe loss of water and electrolytes (salts). An important advance in the treatment of diarrhea has been the discovery that oral rehydration therapy is an effective and inexpensive treatment for dehydration. ORT, which can be prepared and orally administered by mothers or health personnel (in the community, at fixed facilities, and in hospitals), replaces the body fluids and electrolytes lost in diarrheal stools. Thus, it does not prevent or cure the infections that cause diarrhea, but counteracts the dehydration that is the most common cause of death in diarrhea.

Since the late 1960s, when the effectiveness of oral rehydration was first recognized, several ORT programs have been initiated in Egypt, India, Indonesia, Nigeria, Honduras and Guatemala as part of PHC efforts. These programs have had a significant impact on the health status of infants and children as evidenced by the greatly reduced mortality rates and increased weight gains of children receiving ORT. However, other developing countries have only recently begun to initiate ORT activities within their PHC programs. Thus, this project will encourage and assist MOHs in integrating ORT into their ongoing and planned PHC systems activities. The project will also provide technical assistance and commodities to establish or expand either public or private sector oral rehydration therapy programs and production facilities.

b. Immunization

At present there are six major, worldwide childhood communicable diseases which can be prevented with vaccines - tuberculosis*, diptheria, pertussis, polio, measles, and tetanus. (Immunization of pregnant women against tetanus is also a factor in reducing infant mortality.) In some areas, other diseases, such as meningitis are being attacked through immunization of children.

In many countries, immunizations are often delivered through a vertical or categorical program and in some areas or countries this approach may be the most appropriate. However, there are reasons for considering whether immunizations should be integrated into PHC systems: (1) developing countries do not have the resources (e.g. skilled personnel, finances, transport

* The results of a recent CDC/WHO study in India have raised questions about the effectiveness of BCG vaccination against tuberculosis. Subsequent to the publication of these findings, a WHO Study Group recommended the following guidelines for BCG use, "... in areas with a high prevalence of tuberculosis, BCG should be given as early in life as possible... In general, where more than 5 percent of children aged 10 - 14 years have been infected, BCG should be given at birth; where rate is more than 2 percent but less than 5 percent it should be given at school entry; and in places with less than 2 percent of children infected at 10 - 14 years BCG could be given at 12 - 13 years, thus affording maximum protection over the years of puberty."
Source: "BCG Vaccination after the Madras Study," The Lancet, February 7 1981, pp. 309-10.

vehicles, etc.) to field and maintain both vertical disease control and integrated, PHC efforts, (2) those targeted for immunization programs (children under two and pregnant women) are precisely those who would benefit from other PHC interventions; and (3) PHC workers can play an important role in community participation in immunization efforts.

Integrating immunization activities with other health services requires careful planning and coordination, since the maintenance of a cold chain and vaccine quality control require the additional training of health personnel and are essential to the effectiveness of the vaccination programs. The PHC Tech project will promote the integration of immunization activities, wherever technically, socially and financially feasible, into ongoing and planned primary health care programs.

c. Additional Disease Control Interventions

While the disease control component of this project will focus primarily on ORT and immunization interventions, it is recognized that many countries have other important disease control problems. Therefore, the project will be able to provide technical assistance targeted at the control of other diseases which pose serious health problems and for which an effective intervention exists which could be undertaken within the PHC context. For example, assistance could be provided for integrating the administration of chloroquine for the presumptive treatment of malaria into PHC activities.

Illustrative ORT, immunization and additional disease control assistance

Examples of the technology transfer for disease control are:

- Assistance for design and review of epidemiological analyses and surveillance of major diseases;
- Assistance in planning for the integration of ORT activities into existing maternal and child health (MCH) programs;
- Development/adaptation of curricula for training health workers and users in the preparation and use of oral rehydration salts (ORS).
- Adaptation of training materials for supervisors of PHC workers responsible for providing ORT;
- Assistance in developing or improving ORS production facilities (either public or private sector);
- Assistance in tasks related to the commercial distribution of ORS;

- o Assistance related to social marketing of ORS;
- o Assistance for the design and implementation of Expanded Program of Immunization (EPI) - related activities;
- o Development/adaptation of technical manuals for health workers regarding immunization dosages, intervals between doses, vaccine storage temperatures, etc.

d. Commodities and Supplies

In most cases the PHC Tech project will provide only technical assistance through expert services and technical information. However, in a limited number of cases, the project will be able to provide (particularly with geographic supplements to the project budget) modest amounts of commodities such as ORS packets, production equipment for ORS, vaccines, cold chain equipment, training manuals or other appropriate commodities as part of the assistance given by the project to a specific country. As the budget shows, only limited funds are available for commodity support. It is not the intent of this project to supply any elaborate or costly equipment or to provide any commodity on an ongoing, recurrent basis. Commodities are intended to serve as a catalyst or stimulus to bilateral, other donor, or host country activity. Before any commodities are provided, with project funds, careful consideration will be given to future need for the commodity(ies) and the ability of host countries or the willingness of other donors to meet continuing commodity needs.

The following are examples of situations where one time per project commodities assistance would be encouraged:

ORT and VACCINES:

- o Only a limited amount of ORS or vaccine is needed for demonstration pilot project purposes.
- o An immediate supply of ORS or vaccines is not available from UNICEF or other donor sources, but is expected to be available from these or other sources on an ongoing basis.
- o Only a limited amount of ORS or vaccine is needed to create a buffer stock.
- o Limited equipment is required for a demonstration, pilot project.
- o A modest investment in equipment will significantly improve the production capability of existing ORS facilities.
- o Limited equipment is needed as part of a multi-donor effort to institute ORT production.

2. Technical Assistance for Management, Training and Project Design and Evaluation

Although the primary emphasis of this project will be on disease control technologies, the best efforts at technology transfer will not succeed until health personnel are appropriately trained and PHC management systems are strengthened. Since the U.S. has a rich body of theory and techniques in thefields of health management, personnel development and project design and evaluation which can be valuable to developing countries, this project will also provide technical assistance in those areas.

As shown by the two alternative budgets for the project, up to 700 person months of technical assistance with regional bureau and mission support or 320 person months with only S&T/H funds will be provided over the LOP for management, training, and project design and evaluation.

a. Management

As developing countries seek to provide PHC services to rural areas, they face a multitude of management problems. Adequate supervision and drug supply become critical for the kind of decentralized operations required by PHC health services. Poor planning often results in little or no coordination among outlying geographic areas leading to costly duplication and serious gaps in facilities and services. Information systems often lack appropriate data for planning, monitoring and evaluation purposes. Problem solving-oriented technical assistance will be provided through this project for a variety of management tasks, some examples of which are given below:

- Evaluation and improvement of public and /or private sector health management practices, including financing;
- Establishment or re-design of drug supply systems;
- Determination of mechanisms for community involvement in PHC policy formulation and management;
- Establishment or re-design of an appropriate health management information system (manual or micro-computerized),
- Planning of a referral system for PHC workers;
- Planning or redesign of a supervisory system for PHC workers;
- Establishment or redesign of MOH or health facilities financial accounting systems.

b. Personnel Training and Development

At present, PHC systems in most developing countries suffer from a variety of personnel development problems, e.g. insufficiently trained personnel, lack of in-country training capability, insufficient supervision, and lack of the role definitions or performance incentives for key personnel. Although improvements in management systems will ameliorate some of these problems, developing countries also need to develop and improve their own training capabilities through utilizing competency-based training for intermediate and village-level health workers.

Competency-based training focuses on developing competency in specific skills necessary to do a particular job. It follows a particular sequence of curriculum development which is usually characterized by:

a. Definition of program objectives;
b. Definition of program functions;
c. Task analysis of program functions;
d. Grouping of tasks into program personnel roles;
e. Definition of knowledge and skills required for each task;
f. Curriculum development for each role based upon competencies needed.

This project will not finance training programs on a long term basis. However, the examples given below are illustrative of other ways this project could be utilized to strengthen personnel development for PHC activities.

- Evaluation of PHC personnel needs,
- Assessment of host-country training infrastructure,
- Assistance in developing a plan for strengthening training capacity,
- Adaptation of previously developed training materials and modules for use in a specific setting;
- Revision of community health worker training curriculum which is too complex or curatively oriented;
- Design of in-service courses to improve supervisory or other management skills;
- Provision of information on existing training centers or advanced training programs in other countries.

c. Design and Evaluation

Responses by USAIDs to the PHC Tech PID cable indicated that missions often have needs for short-term technical assistance to meet project design and evaluation requirements. While it is expected that missions will assure that each bilateral project contains sufficient funds for project-related short-term technical assistance, including that for evaluation, needs which Missions were unable to anticipate can be met under this project.

3. Information Services

Over the past decade, a great deal of experience in the design and delivery of PHC services has been gained, and much has been and continues to be written about these experiences. The majority of Missions responding to the PHC Tech cable favored provision of selective information support services through the project. Technical information on ORT, EPI and training technologies will be available through reference materials, technical updates and in-service health officer training. While an information center which can be totally responsive to individual technical requests is desirable, the financial implications of such an undertaking are beyond the scope of this project.

a. PHC Information Center (IC)

A small reference library will be established to serve as a resource for the contractor in supporting responses to technical assistance requests from the field, for AID/W staff, and for Mission personnel on temporary duty in Washington. The IC Reference Library will contain selected books, journals, technical reports, evaluations, and project- and country-specific information, where appropriate, which pertain to ORT, immunization, and key training and systems management technologies. A list of consultants with expertise in the areas to be covered by the project, including descriptions of previous field experience and language capability, also will be kept as part of the contractor's data base. Health Officers will be able to receive information on ORT and immunization on request.

In addition, the contractor will be responsible for drafting five Annual Technical Updates--one to be issued to ST/HEA during each year of the project. These reviews will provide the most current technical information on ORT, EPI, management and training technologies. The specific content of these updates will be determined by the Project Manager in consultation with the contractor. Data will be culled from a variety of governmental, private and field programs and studies. It will be analyzed and put into succinct report format for the use of the Director, ST/H. The Director will then copy and circulate these Annual Technical Updates to the USAIDs and Regional Bureaus.

b. Technical Conferences

Complementing the exchange of technical information provided through the PHC-IC is a conference component.

Two regional, PHC technology conferences will be developed per year for four years of the contract (8 total) to provide for up-to-date technical information exchange and dialogue among those responsible for designing and implementing PHC programs, including contractors, PVOs, host country and A.I.D. participants, in the area of PHC technologies for disease control, management and training and to share PHC experiences, problems and solutions. During the 3rd year of the contract a world-wide conference will be held. The contractor will, in conjunction with the A.I.D. project manager and appropriate Regional Bureau staff, plan the agenda, staffing, time and place for the conference, provide for the salary, per diem and travel costs of the conference staff; provide conference rooms and materials needed to support the conference program; conduct and evaluate the conferences and prepare the final conference report. Travel and per diem for A.I.D. and host country participants will not be provided by the project, except when the latter are used in training roles. A.I.D. personnel travel will be covered by operating expense funds.

c. Beneficiaries

It is intended that the ultimate beneficiaries of this project be the poor majority in developing countries who receive the PHC services for which this project provides supporting assistance. Since a good proportion of the project resources are focused on ORT and immunizations, infants and children under five will particularly benefit from the PHC Tech project. Other beneficiaries of this project will be host country institutions, both in the public and private sectors, whose management and/or personnel development systems are strengthened as a consequence of PHC Tech project activities. Finally, (personnel involved in the planning and implementation of PHC programs in LDCs will benefit from the availability of technical assistance and information services provided by this project.

5. Relationship of Project to Other A.I.D. and Donors' ORT and EPI Efforts

In addition to A.I.D., there are numerous private voluntary and non-profit organizations, other bi-lateral donors and development banks or multilateral agencies which are supporting developing countries' efforts to provide PHC services. It is the intention that the PHC Tech project resources complement and strengthen these efforts, not duplicate or undermine them.

At present, A.I.D. has bilateral, regional and centrally-funded activities which are providing assistance with ORT and immunization activities. (see Annex C , Tables C.1 and C.2). Furthermore, WHO and UNICEF offer ORT assistance through the Diarrheal Disease Control Programme (CDD) and immunizaton assistance through the Expanded Program in Immunization (EPI). UNICEF assists indigenous manufacturers in developing local production capability for vaccines and ORS packets, and provides ORS packets worldwide.

In countries, where either A.I.D. (through ongoing bilateral or regional, e.g. CCCD projects), WHO or UNICEF is established in a significant leadership role in the development of CDD or EPI programs, PHC Tech resources may be useful for support of their on-going efforts. In countries where other donors are

not active, or are active in only certain regions, use of PHC Tech resources for a wider range of program needs is anticipated.

The following protocols will be followed in order to minimize overlap of PHC Tech resources with those of other donors, or other bureaus in A.I.D.:

(1) USAID Health officers who wish to request technical assistance or commodities for the transfer of ORT or immunization technologies will first discuss it with the Ministry of Health and local WHO EPI or CDD coordinators and the UNICEF representative to determine that such an activity has not been already carried out and is complementary to the efforts of WHO and UNICEF;

(2) The PHC Tech project manager and project contractor will schedule a two-day annual exchange of information with the EPI and CDD coordinators of WHO headquarters and PAHO, and UNICEF headquarters' representatives. Meetings with the staff of these organizations will take place in the headquarters of one of the organizations.

III. IMPLEMENTATION

A. Roles of Participating Parties

1. USAIDs/Host Countries

USAIDs, representing their host countries, have several important roles in this project. USAIDs (a) can request technical assistance, commodities or information, (b) will be consulted for approval on requests for technical assistance or commodities in their host countries that are not USAID-initiated, (c) will be responsible for informing the ST/Hea project manager and contractor of any deficiencies in the execution of tasks by contractor staff, (d) will be responsible for the completion and submission of performance critiques, and (e) will be responsible for approval of draft consultants' reports before they are formally issued.

2. Regional Bureaus

Regional Bureaus have the same roles as outlined above for USAIDs when project activities are requested by a Regional Bureau. In addition, Regional Bureaus may wish to comment upon the Scope of Work for the services requested by their USAIDs and advise whether the activity would be more appropriately carried out under another project. Furthermore, evaluations from the Regional Bureaus with respect to the content, presentation and timeliness of the consultants' reports will be requested, where appropriate.

Regional Bureaus will also be responsible for providing initial guidance on the topics for and general organization of the PHC technology conferences for their region.

Regional Bureaus will determine anticipated demand for technical assistance, commodities information services by their USAID's biannually or annually and issue appropriate PIO/T's supplement S&T/H funds in the contract.

There will be an annual meeting of Regional Bureau Health Officers to provide an update on overall project activities and future directions. This will include both programmatic and financial reports from the contractor and ST/H project manager and presentation of any external evaluation results.

3. ST/H Project Manager

In order to ensure successful implementation of this project ST/H will make available approximately nine person months per year for project management. The ST/H Project Manager will serve as a coordination point for all inter-actions between the contractor and Missions, Regional Bureaus, PPC and other Agency offices requesting services under the contract, and will assure that the contractor and Contracts Office are in sufficiently close communication.

The Project Manager, after discussions with the appropriate Regional Bureau personnel, will give the final approval for requests for services that come in from USAIDs or AID/W bureaus. It will be the responsibility of the Project Manager to review all requests for services and determine whether or not the services requested fall within the scope of the project and that sufficient funds are available for execution of this task.

Subsequent to approval of the requested/suggested services, the Project Manager will prepare an "Order of Technical Direction" (OTD) which will instruct the contractor to finalize the scope of work, will set the level of effort, and will authorize international as well as in-country travel, car rental, equipment purchase, per diem, etc. Once the OTD is forwarded, the contractor will mobilize resources, identify and adapt the appropriate technologies to the country-specific problem in coordination with the Mission, host country or A.I.D. office requesting the service. The contractor will not be able to meet requests for services without written authorization from the Project Manager to the contractor in the form of an OTD.

4. External Review Panel

An external review panel will be formed to provide technical advice to review project activities, periodically. It will consist of six to eight persons chosen for their expertise in ORT, EPI, management and training. Among these individuals, there must be either representation or close working knowledge of the private sector pharmaceutical industry; the Centers for Disease Control/HHS and the UN System (WHO, UNICEF, PAHO).

Review panel meetings will be scheduled three times during the first year of the project and twice yearly in each subsequent year of the project. Other meetings may be called if necessary to deal with immediate technical issues.

5. Contractor

The contractor must have in-house technical expertise as well as a knowledgeable, experienced, and available consultant base to provide technical assistance in the following areas in priority ranking:

a. ORT, immunization and other disease control activities,

b. Health management and competency-based training of mid-level and community health workers.

The contractor will also have to be capable of:

a. Fielding short-term technical consultants in a timely fashion and preparation of consultants' final reports for A.I.D. and host country use;

b. Developing an information service for A.I.D. in the area of selected PHC.

c. Developing and managing conferences on PHC topics of interest to LDC health planners and managers.

d. Delivering PHC commodities in as rapid and efficient a manner as possible.

In addition, the contractor staff must have a demonstrated experience in dealing with a U.S. Government Agency, preferably A.I.D., and working with developing country institutions. We have determined that there are private organizations which are willing and able to fulfill these requirements. The contractor will be provided with sufficient funds, coordination, direction, responsibility and authority to provide for the detailed planning, management and logistics support for the technical assistance teams and information services. The contractor will provide interpreter services where appropriate, administratively coordinate all responses to requests for services, logistically and administratively support teams in the field, transport commodities and materials, print and bind documents and prepare final reports as specified in OTDs.

The contractor will be responsible for provision of adequate facilities preferably in the Rosslyn, Virginia area to house information materials and salaried full-time core staff to manage the technical assistance activities envisioned for the project.

B. Project Implementation Schedule

ACTION	DATE
1. Approval of PP	Feb 1983
2. Approval of PIO/T for FY 83 Funding	Feb 1983
3. Advertisement of RFP	Mar 1983
4. Receipt of Proposals	May 1983
5. Review of Proposals and Contractor Selection	Jun 1983
6. Contract Negotiation/Signature	Jul 1983
7. Contractor Initiation of Services	Aug 1983
8. Approval of PIO/T for FY 84 Funding	Jan 1984
9. FY 84 Contract Funding Amendment Signed	Feb 1984
10. A.I.D. Annual Review	Jul 1984
11. Approval of PIO/T for FY 85 Funding	Jan 1985
12. FY 85 Contract Funding Amendment Signed	Feb 1985
13. A.I.D. Annual Review	Jul 1985
14. Approval of PIO/T for FY 86 Funding	Jan 1986
15. FY 86 Contract Funding Amendment Signed	Feb 1986
16. Mid-project Evaluation	Feb 1986
17. A.I.D. Annual Review	Jul 1986
18. Approval for PIO/T FY 87 Funding	Jan 1987
19. FY 87 Contract Funding Amendment Signed	Feb 1987
20. A.I.D. Annual Review	Jul 1987
21. Final Evaluation and End of Project	Jun 1988

IV. Evaluation

Two types of evaluation are planned for this project. A continuous evaluation process will take place throughout this project as a result of Performance Critiques, (required of each Mission or AID/W bureau upon completion of services they requested which result in an OTD), and annual reviews of the outputs of the Project by the Project Manager. In addition, there will be two external evaluations of the overall project by teams of outside experts and A.I.D. staff. Reports from the annual reviews and external evaluations will be shared with the Regional Bureaus and PPC.

A. Performance Critiques will be forwarded to the Project Manager, contractor and Regional Bureau by each Mission at the completion of the contractor's involvement with each task requested. Critiques will include ratings for each individual consultant utilized (based on their technical expertise, ability to apply their expertise to the problem identified, etc.) and the overall performance of the contractor in fielding and following up OTD's. It is anticipated that the technical assistance provided, as well as the handling of requests for services or commodities will improve during the life-of-project as a result of utilizing the information provided in these Performance Critiques.

B. Annual Reviews

Annual Reviews by the Project Manager will summarize by region, and within region by type of assistance, the activities funded by the Project over the preceding year, information from the performance critiques, changes in the policies or operating procedures of the project, an analysis of how project funds were utilized and a pipeline analysis of whether the funds remaining over the life of the project are likely to be adequate given demand to date for PHC TECH assistance.

C. External Evaluations

An external mid-point evaluation is tentatively scheduled for early 1986. The evaluation team will consist, preferably, of a mix of three external evaluators and one A.I.D. representative who will review project documents, talk with relevant persons in AID/W and USAIDs (by telephone), and put together the evaluation report over a 2 week period. The mid-point evaluation may result in changes in the direction, emphasis or administrative procedures of the project. The evaluation should focus on the following points related to implementation and project performance to date:

- Appropriateness of project design;

- Effectiveness of project to date in achieving project outputs, and revisions necessary to assure achieving project purpose;

- Adequacy of resource mix among project components (i.e., disease control, management and training TA and commodities, and the more general, rapid response TA; information services and conferences);

- Adequacy of project budget given the demand to date for services and the actual costs of providing the TA, commodities, and information services requested;

- Adequacy of contractor management and administration;

- Adequacy of coordination between project efforts and other A.I.D.-assisted or other donor funded efforts;

- Consideration of the need for a follow-on project;

- Recommendations of possible modifications or adjustments to the project design or funding as a consequence of the above reviews.

A final in-depth external evaluation will tentatively be scheduled for the early summer 1988. The evaluation team will consist, preferably, of three external evaluators and one A.I.D. representative reviewing project documents and talking with appropriate A.I.D. and other donor personnel for approximately two weeks, with a subsequent third week for writing up the evaluation report. The evaluation will focus on the following:

- Appropriateness of original project design and modifications made during life-of-project;

- Assessment of the contractor's performance and adherence to the contract and individual OTDs;

- Quality of TA provided;

- Adequacy of information services in filling information gaps perceived by many Missions;

- Impact of the project on the PHC programs of PHC Tech-assisted countries;

- Lessons learned for use in a follow-on or subsequent project of this nature.

The final scheduling for both the mid-point evaluation and the final evaluation will be determined once the project is underway.

V. Budget and Financial Plan
($000)

	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Technical Assistance	1,131	1,930	2,286	2,917	2,236	10,500
Contractor Staff	730	781	835	894	956	4,196
Commodities	300	500	600	600	500	2,500
Information Center	30	20	15	14	10	89
Conferences	60	60	40	60	60	280
Office Space	52	53	53	56	56	270
Other Direct Costs	50	--	--	--	--	50
Sub-total	2,353	3,344	3,829	4,541	3,818	17,885
Fee @ 6%	141	201	230	272	229	1,073
TOTAL Contract	2,494	3,545	4,059	4,813	4,047	18,958
Evaluations	--	--	15	--	35	50
TOTAL Project	2,494	3,545	4,074	4,813	4,082	19,008

A. Description of Project Items

TECHNICAL ASSISTANCE

$470/person/day x 20 days (1 month) = $9,400/person month (pm) of TA

Projected TA requirements:	Year 1	121
	Year 2	205
	Year 3	243
	Year 4	310
	Year 5	238
	TOTAL	1117 pm of TA

1117 pm of TA x $9,400/pm = $10,500

This represents approximately 400 pm of TA for ORT, EPI and 700 pm for general technical assistance.

CONTRACTOR STAFF

Salaries:

Director	$ 63,000
Technical Advisor	$ 45,000
Technical Advisor	$ 45,000
TA Logistics Mgr./ Conference Mgr.	$ 30,000
Editor/Information Mgr.	$ 35,000
Comptroller	$ 25,000
Secretaries (4 @ $13,000)	$ 52,000
Clerk/Messenger	$ 9,000
TOTAL	$ 304,000 / year

Overhead: $ 425,000

140 percent includes
Fringe Benefits 18-23 percent
General and Admin. 8-20 percent

Sub-total of Salaries and Overhead with 7 percent increase/year (inflation)

Year 1	$ 729,600
Year 2	$ 780,672
Year 3	$ 835,319
Year 4	$ 893,791
Year 5	$ 956,357
TOTAL	$4,195,739

COMMODITIES

See Notes to the PHC Tech Financial Plan, Note 2.

INFORMATION CENTER

Annual Technical Update	$ 5,000[3]
IC Reference Library: cost of books, journals, pamphlets, xeroxing, distribution	$ 84,000
SUBTOTAL	$ 89,000

CONFERENCES

8 Regional technical conferences @ $30,000/conference	$ 240,000
1 Agency-wide technical conference @ $40,000/ conference	40,000
SUBTOTAL	$ 280,000[4]

OFFICE SPACE (3,500 sq. ft.)

Year 1 (@ $15/sq.ft.)	$ 52,500
Year 2 (@ $15/sq.ft.)	$ 52,500
Year 3 (@ $15/sq.ft.)	$ 52,500
Year 4 (@ $16/sq.ft.)	$ 56,000
Year 5 (@ $16/sq.ft.)	$ 56,000
SUBTOTAL	$ 269,500

OTHER DIRECT COSTS

Computer	$ 20,000
Office Furniture	$ 30,000
SUBTOTAL	$ 50,000

EVALUATIONS

1 mid-term external evaluation 3 persons for 2 weeks=1.5 pm @ $10,000	$ 15,000
1 final external evaluation 3 persons for 3 weeks = 2 pm = $20,000 Travel, per diem, and O.D.C. = $15,000	$ 35,000
SUBTOTAL	$ 50,000

FEE

6 percent of contract budget of 17,885,000 = $1,073,000

B. Notes to the Financial Plan:

1. The project is designed with the bulk of funds--12 million of the 19 million LOP budget--coming from the ST/HEA account with up to 7 million coming from Regional Bureau and Mission transfers. An estimated $500,000 is expected in transfers for the first year of the project, with increasing transfers in subsequent years as the demand for technical assistance and information services grows. Regional transfers will be used primarily for general technical assistance requests, commodities, and conferences. However, a portion of the regions' transferred monies must cover managerial, administrative and overhead costs as well.

2. It is not possible at this time to delineate exactly how the commodity budget will be used over the life of the Project. However if the budget were to be used for any single commodity, it could buy that commodity in the following quantities:

	ORS	20 million packets
or		
	ORS semi-automatic production systems	28 systems
or		
	ORS automatic production systems	12 systems

The cost of the ORS production systems is exclusive of the costs of the ingredients or packaging materials.

3. The budget estimates for the annual technical updates are exclusive of personnel costs, but include the cost for computerized information searches, xeroxing, etc.

4. USAID staff and host country counterparts' travel and expenses are not included in these estimates. The estimated budget is intended to cover salary, per diem and travel costs of conference staff, rental costs of facilities, interpreter services, provision of documentation, xeroxing, and secretarial, registration, and receptionist assistance.

Budget and Financial Plan II
(W/only anticipated ST/Hea Contribution and No Regional Bureau Transfers)
($000)

	Year 1	Year 2	Year 3	Year 4	Year 5	TOTAL
Technical Assistance	1,200	1,200	1,200	1,200	1,200	6,000
Contractor Staff	730	781	835	840	956	4,142
Commodities	100	100	100	100	100	500
Information Center	30	20	15	14	10	89
Conferences	30	30	40	30	30	160
Office Space	52	52	52	56	56	270
Other Direct Costs	50	--	--	--	--	50
Evaluations	--	--	8	--	12	20
Fee	144	144	144	144	144	720
TOTAL	2,336	2,327	2,394	2,384	2,508	11,951

Differences between the $19 and $12 million budgets:

- o $6,000,000 for TA = 640 pm
- o 64 pm/year for ORT and EPI TA, total 1,320 pm rather than 400 pm
- o 64 pm/year for health management, training and design and evaluation TA*, total 320 pm rather than 700 pm
- o only 1 health officers conference/region and one global conference
- o reduction in commodities from $2,500,000 to 500,000

*Note: Utilization of the ADSS contract averaged 66 pm/year for general technical assistance.

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ANNEX A
PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

ANNEX: PHC Tech Logframe
Life of Project:
From FY 83 to FY 87
Total U.S. Funding 19,000,000
Date Prepared: January 1983

Project Title & Number: Technology for Primary Health Care (PHC Tech)

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
Program or Sector Goal: The broader objective to which this project contributes: To increase the impact of health sector activities on improving the health status of LDC populations, especially of infants and children.	Measures of Goal Achievement: Reductions in infant, child, and maternal morbidity and mortality in developing countries assisted by this project.	Vital statistics or epidemiologic data from MOH records, health facility aid program data or special health surveys.	Assumptions for achieving goal targets: - That the disease control technologies selected are effective in reducing infant and child morbidity and mortality. - That the impact of health sector programs is related to how effectively they are managed and how well health workers are trained.
Project Purpose: To make PHC Systems more effective by introducing improved disease control technologies, particularly ORT and immunizations, and by improving management and training.	Conditions that will indicate purpose has been achieved: End of project status. Twenty country PHC projects utilize PHC Tech. services to adopt or improve utilization of ORT or immunization measures within their PHC programs. Twenty countries utilize PHC Tech. services to adopt or improve other disease control measures, management techniques, or training systems.	Contractor records and monthly reports. Annual project manager reviews. Performance critiques and phone interviews with A.I.D. staff. Increased demand for and use of ORS, vaccines and other technologies.	Assumptions for achieving purpose: - MOHs cooperate with/encourage technology transfer from A.I.D. - Govts. of Dev. Countries maintain or increase support and resources available for PHC. - USAID Missions continue to promote the development of integrated PHC systems and improvement in the health sector as part of the Agency's Development Assistance Plan.
Outputs: Increased knowledge among AID and LDC health development personnel of policy and program options and technical requirements for utilizing selected PHC technologies such as ORT and EPI. Country-specific information on policy and program options and technical or managerial methodologies for ORT, EPI and other key PHC technologies. Resolution of key program and technical difficulties in the design, implementation or evaluation of ORT, EPI and other key components of PHC programs.	Magnitude of Outputs: Annual technical updates received by all USAID's. Health personnel from host countries, AID, contractors and PVOs trained at conferences, approximately 100 per year. Country-specific technical analyses for 25 countries. Remedial technical assistance to 30 countries.	Contractor records and monthly reports. Annual project manager reviews Mid-term and final external evaluations.	Assumptions for achieving outputs: Relevant skills and expertise requested by USAIDs will be available through contractor's services.
Inputs: Contractor management services. Technical Assistance to USAIDs, AID/W, and LDCs. Commodities. Informational and training materials.	Implementation Target (Type and Quantity) ($000) Contractor Services 4,142 Core Staff and facilities TA - consultants 10,500 - Staff Commodities 2,500 Information Center 389 Health Officers' Conf. 280 Office Space 270 ODC 50 Evaluation 20 Fee 1,740 18,991	Contractors accounting records. Annual project manager reviews. Mid-term and final evaluations.	Assumptions for providing inputs: - A.I.D. inputs available in a timely fashion. - Contractor/implementation mechanism able to meet broad inter-disciplinary needs.

ANNEX B

REGIONAL BUREAU AND MISSION GUIDANCE AND SUPPORT

The PHC Tech Project has been developed in collaboration wth the Regional Bureaus and has been strongly endorsed by all four Regional Bureaus through the Health Sector Council. The Missions also strongly supported the PHC Tech project as evidenced by their responses to the PID cable sent to the field in April, 1982. Thirty-seven of the 40 missions responding to the cable expressed support for the project, the majority of these being strongly supportive. The number of Missions anticipating utilizing or otherwise benefitting from the services or commodities to be provided in this project are listed below.

		No. of Missions (n= 40)
Technical Assistance		
	ORT	16
	Immunizations	9
	Other Disease-specific	14
	Management	22
	Training	10
	Rapid Response TA	9
Information		
	Information Center	17
	Conferences	11
	Commodities	9

(Details of Mission responses appear on Table 2).

A number of issues about the Project were raised by the Missions or Regional Bureaus during the PID review. These have been resolved as follows:

ISSUE	RESOLUTION
o Other bilateral programs or multilateral organizations are already active in promoting ORT and immunization, management and training activities.	o Certain tasks have been outlined for the USAID, AID/W and the contractor staff which are intended to maximize communication and coordination with the other relevant groups. Project activities are intended to augment existing efforts or provide resources where none exist.
o Other diseases are of concern to USAID staff and host country officials (e.g. malaria). The project focus on ORI and EPI seems too narrow.	o In addition to promoting the transfer of ORT and EPI technologies, PHC Tech will provide assistance with respect to other disease control activities, when (1) no other USAID or central project can meet the request, (2) the disease is a priority area for activity in the health sector stragegy of the host country and the USAID and (3) an effective technology exists for control of the disease which could be appropriately transferred to the developing country.
o It may be inappropriate to provide commodities in a project which has only short-term technical assistance available. Further, AID/W commodity procurement can be overly slow.	o Commodities will only be used to encourage selected disease control initiatives and will be provided only when there exists the in-country personnel to monitor appropriate use. Further, the contractor is expected to be able to more rapidly procure commodities.
o The project should provide travel funds in order to allow USAID staff and host country counterparts to to attend the PHC technology conference.	o Under the Foreign Assistance Act, program funds may not be used to support the travel and per diems of USAID staff. Project funds may be used to fund host country counterparts serving as faculty but are too limited to cover all attendees.

ANNEX C

OVERVIEW OF AID ORT AND EPI ACTIVITIES

The information on the following pages briefly summarizes the ORT and EPI activities of AID. Although the number of countries in which some activities have been initiated is significant, given the magnitude of resources needed to provide even a few select PHC interventions to the world's poor, it is likely that the resources available in this project will not overlap those of other donors or A.I.D. offices.

TABLE C.1

AID-SUPPORTED PROJECTS WITH ORT ACTIVITIES

BUREAU FOR SCIENCE AND TECHNOLOGY

S&T/HEA

International Center for Diarrheal Disease Research (FY 79-85)
Primary Health Care - Operations Research (FY 81 - 86)
Water and Sanitation for Health (FY 80-88)

S&T/EDUC

Mass Media and Health Practices in Honduras and the Gambia (FY 78-84)

S&T/NUT

Nutrition Components for Integrated Health Delivery Systems (FY 82- ___)
Nutrition: Education Field Support (FY 79-83)

S&T/POP

Operations Research in Haiti, Thailand, Tunisia, Egypt, Mexico, Guatemala, Morocco, Nigeria, Peru, Sudan

FOOD FOR PEACE AND VOLUNTARY ASSISTANCE

AID has matching grants with the following PVO's who have ORT activities in their projects.

Foster Parents Plan, International
MAP International
Project Concern

AFRICA BUREAU - bilateral

Mali - Oral Rehydration Unit
- Rural Health Services Development (FY 79-83)

Senegal - USAID assisting GOS in design of national ORT program.

Sudan - Northern Sudan Primary Health Care (FY 79-82)
- Southern Sudan Primary Health Care (FY 79-83)
- Rural Health Support (FY 80-84)

AFRICA BUREAU -Regional

Strengthening Health Delivery Systems (FY 73- ____)
Combatting Childhood Communicable Diseases (FY 82 - ____)

ASIA BUREAU

Bangladesh	- Family Planning Social Marketing Project	(FY 75 - ____)
Burma	- Primary Health Care	(FY 80 - ____)
Indonesia	- Village Family Planning/Mother-Child Welfare	(FY 80 - 84)

LATIN AMERICA AND CARIBBEAN

Bolivia	- Rural Health Delivery Services,	(FY 75 - 81)
Dominican Republic	- Health Sector Loan I and II	(FY 75 - 80)
Ecuador	- Integrated Rural Health Delivery Systems	(FY 81 - 84)
El Salvador	- Rural Health Aide's	(FY 78 - 81)
Guatemala	- Community-base Integrated Health and Nutrition Loan	(FY 80 - 83)
Haiti	- Maternal Child Health/Family Planning II	(FY 78 - 81)
	- Rural Health Delivery System	(FY 79 - 83)
Honduras	- Health Sector I	(FY 80 - 84)
Jamaica	- Health Management Improvement Project	(FY 81 - 85)
	- Health Management Improvement for Young Children	(FY 76 - 80)
Peru	- Extension of Integrated Primary Health	(FY 79 - 82)

NEAR EAST BUREAU

Egypt	- Control of Diarrheal Diseases	(FY 81 - 86)
	- Strengthening Rural Health Services Delivery Project	(FY 78 - 83)
	- Urban Health Delivery System Project	(FY 79 - 85)
Jordan	- Health Education	(FY 80 - 85)
Morocco	- Family Planning Support II	(FY 78 - 83)
West Bank	- Health Education Project	(FY 79 - 82)
Yemen	- Tihama Primary Health Care	(FY 80 - 86)

Source: Drasbek, C. (October, 1981) An Inventory of AID-Supported Activities in Diarrheal Disease Control and Oral Rehydration Therapy, Washington, D. C. AID, Xerox, 38 pp.

TABLE C.2

AID-SUPPORTED PROJECTS WITH EPI ACTIVITIES

BUREAU FOR SCIENCE AND TECHNOLOGY

S&T/POP

Operations research project activities in Egypt, Guatemala, Haiti, Nigeria and the Sudan.

AFRICA BUREAU- bilateral

Kenya	- Kibwezi Primary Health Care	(FY 79 -)
	- Kitui Primary Health Care	(FY 79 - 83)
	- Kitui Rural Health	(FY 81 - 83)
Mauritania	- Rural Medical Assistance	(FY 79 -)
Rwanda	- Rural Health/Family Planning	(FY 81 - 86)
Somalia	- Rural Health Delivery	(FY 79 -)
Zaire	- Basic Rural Health	(FY 81 -)

AFRICA BUREAU- Regional

Accelerated Impact Project	(FY 77-82)
Control of Childhood Communicable Diseases	(FY)

ASIA BUREAU

Indonesia	Expanded Program on Immunization	(FY 79-81)

LATIN AMERICAN/CARIBBEAN BUREAU

LAC/DR reported that nearly all of the LAC health projects had some immunization-related activity.

NEAR EAST BUREAU

Egypt - Strengthening Rural Health Services (FY 78-82)
- Urban Health Delivery Systems (FY79-81)
- Vaccines are provided under the commodity import program.

Jordan - Health Education (FY 78-81)

Lebanon - Bureau provided funding for epidemiolical survey, the results of which will be used in UNICEF immunization effort.

Tunisia - Rural Community Health (FY 78-81)

Yemen - Tihama Primary Health Center (FY 80-)

Source: Information was provided by health officers of the respective Regional and ST Bureaus.