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LAOS

MATERNAL AND CHILD HEALTH/FAMILY PLANNING PROP
(FY 1975 - 79)

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LAOS

MATERNAL AND CHILD HEALTH/FAMILY PLANNING PROP

(FY 1975 - 1979)

A. NEW PROJECT DIRECTIONS

The attached PROP for the Laos MCH/FP project extends the project through FY 1979. The aim of the project in accelerating the demographic transition of Laos has remained unchanged since the beginning of the project in FY 1969. The project has now reached the point of being able to place greater emphasis on the delivery of family planning services, having achieved Lao Government policy support, having completed much of the major construction effort, and having embarked on a substantial training effort.

The new emphasis on service delivery will consist of several components:

1. Expanded clinical coverage will be achieved by providing family planning services through a greater number of existing MCH clinics. The project will extend family planning services to about 60 new clinic locations during FY 1975 and to an additional 50 during FY 1976. (At present FP services are available at 130 clinical outlets throughout Laos.)
2. Greater post-partum FP service delivery will be achieved by instituting post-partum programs in all existing hospitals over the two-year period. (At present only two of the Ministry of Public Health's 15 hospitals provide this service.)
3. Extensive in-service training will qualify existing MCH personnel to provide family planning services and information. The primary target group for this training will consist of the two-year auxiliary midwives who currently staff many of the rural MCH clinics; similar in-service training will be extended to two-year medics and to rural midwives. Greater emphasis on family planning service delivery will also be introduced into the formal curricula of the Lao Government's medical and nursing schools.
4. The project will emphasize improvements in the commodity management and logistic network of the Ministry of Public Health to insure a timely and adequate distribution of contraceptives and medical commodities throughout the delivery system.

5. As a corollary to the training of medical auxiliaries, the MCH/FP project will assist the Ministry of Public Health in expanding the delivery of FP services through this body of para-professional personnel in order to gain maximum effectiveness from all levels of medical manpower.

6. In addition, the MCH/FP project will pursue the development of non-clinical delivery systems for family planning services and information through such pilot activities as the establishment of outlets on market grounds.

7. Similarly, the project will examine the roles which it can play in encouraging the spread of FP services through private sector physicians and traditional medical practitioners.

One of the major initiatives which the project will undertake during FY 1975 will consist of a long-term implementation schedule for increasing contraceptive coverage throughout the fertile population. This set of annual targets for acceptors and continuation rates will provide a useful management tool and will allow for on-going evaluation of project performance. It will also provide specific guidelines for implementing the Lao Government decree on population, which calls for a 50% reduction in birth and death rates by the turn of the century.

The MCH/FP project during FY 1975 - FY 1976 will place greater emphasis on factors designed to increase popular demand for FP services, primarily through the development of more widespread information, education and communication activities. To this end, the project will call on the services of a full-time I. E. C. advisor beginning in FY 1975.

Another new emphasis in project direction will stress the integration of related activities, with particular reference to nutrition. The project will continue to pursue close integration with the National Health Development project to insure the most effective use of scarce U.S. and Lao Government resources. Similarly, the project will be carried out in close coordination with other aid donor activities in MCH/FP and related fields.

Finally, the project will continue to stress the long-standing objective of developing the Lao Government's physical infrastructure for Maternal Child Health and Family Planning service delivery by providing for MCH/FP wings at Luang Prabang in FY 1975, and at Savannakhet in

FY 1976. The establishment of these two provincial centers, along with continued renovations to rural centers, will complete the project design for delivery system and in-country training facilities.

B. PROJECT FUNDING

Funding for the MCH/FP project will be apportioned between "Title X" on the one hand, and Section 104 health funds or IPRA funds on the other.

While the Mission feels that the Congressional mandate of Section 104 reaffirms the validity of the integrated MCH/FP approach which the project has always followed, the Mission defers to AID/W for final determination of funding sources for the several components of the project. The Mission has, nevertheless, prepared a proposed budget breakout, by funding source, for FY 1975 and FY 1976 which appears below. In this breakout, Title X assumes funding responsibility for personnel, training, contraceptives, vehicles and parts, POL, I.E.C. activities, local currency costs (primarily for salaries) and sundry operational support. Health or IPRA assumes funding responsibility for construction, renovation, hospital equipment, and commodity transportation. Medical commodities are funded jointly.

SOURCE OF FUNDING

	<u>"Title X"</u>		<u>"IPRA, Health, etc.</u>	
	<u>FY-75</u>	<u>FY-76</u>	<u>FY-75</u>	<u>FY-76</u>
<u>PERSONNEL</u>				
U.S.D.H. (3)	(2) 1/ (150.0)	(2) 1/ (150.0)		
Consultants, I.E.C.	9.0	-		
Logs	9.0 ✓	9.0 -		
AHA	8.0 ✓	8.0 -		
TCN's				
O.B.	130.0	130.0		
Maint. Techs.	10.0 ✓	12.0 -		
	<u>166.0</u>	<u>159.0</u>		
	139	130		

1/ Non-add; - funded by Operating Expenses

SOURCE OF FUNDING (Continued)

"Title X"	<u>FY-75</u>	<u>FY-76</u>	<u>"IPRA", Health, etc.</u>	<u>FY-75</u>	<u>FY-76</u>
<u>COMMODITIES</u>					
Contraceptives	152 134.0 ^{2/}	147.0 ^{2/}	Hospital Equipment	110.0	209.0
Vehicles	-	7.0	GFM	50.0	60.0
Motorbikes	5.0	1.0	Re-Bar	0.5	0.5
POL	9.0	8.0	Cement	0.5	0.5
Repair Parts	5.0	2.0	Medical Commodities	300.0	315.5
General Supplies	50 2.0	2.0		<u>461.0</u>	<u>585.5</u>
Medical Commodities	214.0	224.5 ⁷⁹			
	<u>369.0</u>	<u>391.5</u>			
	329	246			
<u>TRAINING</u>					
	27.0	23.5			
<u>OTHER COSTS</u>					
Local Currency Costs	64.0	65.0	L. P. Construction	600.0	-
I. E. C.	30.0	30.0	SVKT Construction	-	440.0
Misc. Contract Services	10.0	10.0	Transportation	50.0	50.0
MRO	12.0	12.0	Commodities Air Transport	20.0	20.0
Operational Travel	6.0	6.0	Rural Renovations	10.0	7.0
	<u>122.0</u>	<u>123.0</u>		<u>680.0</u>	<u>517.0</u>
<u>TOTAL</u>	617 <u>684.0</u>	522 <u>697.0</u>		<u>1,141.0</u>	<u>1,102.5</u>
MISSION Agmt only to	550 325	375			
<u>GRAND TOTAL</u>	FY 1975	\$1,825.0 (Excluding U. S. DH salaries)			
	FY 1976	1,799.5 (Excluding U. S. DH salaries)			

2/ Centrally funded - not included in Mission allotment.

C. OPERATION BROTHERHOOD PUBLIC HEALTH FIELD
OPERATION TEAM FAMILY PLANNING DELIVERY SERVICES

State 163498 requested additional information on the FP delivery services provided by the 20-man OB Public Health Field Operations Team, with particular reference to the number of acceptors recruited through these facilities.

Although the number of acceptors attributable to the rural activities of the team has been low in the past (reference Mission bi-monthly FP statistical reports), during the first six months of operation the post-partum program sponsored by the team has recruited over 16% of all new acceptors during the period November 1973 - April 1974. Since the beginning of the post-partum program, over 60% of all obstetrical admissions have accepted a method of contraception. This program will be expanded to all OB-staff hospitals in Laos during FY 1975.

Each year the team conducts over 100 man-months of training in FP service delivery to upgrade local personnel. The team has also provided I. E. C. and training materials that have been widely distributed and used by the Ministry of Public Health and the USAID/Village Health Program.

As noted in Section B above, and in the body of the PROP below, the MCH/FP project will support the OB Public Health Field Operations Team with \$130,000 annually for FY 75-FY 77. This represents about two-thirds of the total costs of the team's overall program, which also includes activities in nutrition and public health. The Mission has elected not to provide funding support through the MCH/FP project for the MCH/FP service delivery activities carried out by the other components of the OB operation. Were these activities to be funded by the MCH/FP project, additional support of no less than \$200,000 would be required.

D. SECTION 110(A) DETERMINATION

In view of the fact that this project will be partially funded by IPRA appropriations which are not subject to the Section 110(A) determination, and because the proportions of the funding split will be established by AID/W following review of this PROP, the Laos Mission is not able to precisely calculate the percentage contribution of the Lao Government vis-a-vis USG inputs under Section 104. Similarly, the Mission does not know whether or not U.S. direct-hire salaries funded from Operating Expenses are to be included on the U.S. side of the Section 110(A) determination.

The attached PROP shows on pages 13-14 the Lao Government's contributions to the MCH/FP project for the period January 1974 through FY 1979. Similarly, the PROP face sheet shows estimated RLG budgetary inputs to the project on a fiscal year basis, excluding the contributions in kind (land) which are included in the Input Tables on pages 13-14.

The total Lao Government contribution to the MCH/FP project for the period January 1974 through FY 1979 is estimated to be \$5,608,000. This consists of the following major components, which are further broken down on pages 13-14 of the PROP.

	<u>(\$000)</u>
Personnel	1,702
Facilities (incl. land)	3,408
Commodities	498
Total	<u>5,608</u>

This figure should be used in preparing the final Section 110(A) determination when the project funding split has been established by AID/W.

In the meantime, it is nevertheless clear that the Laos MCH/FP project will meet the criteria of Section 110(A) no matter what funding split emerges. Total AID inputs, both Section 104 and IPRA, including salaries funded from Operating Expenses, come to approximately \$8,136,000 for the period January 1974 through FY 1979. Using this figure, the following relationship exists between U.S. funding and Lao Government funding:

	<u>(\$000)</u>	<u>(Percent)</u>
Lao Government	5,608	41%
U.S. Government	<u>8,136</u>	<u>59%</u>
Total	13,744	100%

The FY 1975 MCH/FP draft Project Agreement contains the following provision pursuant to Section 110(A):

LAO GOVERNMENT CONTRIBUTION

"The Lao Government will provide the following contributions from January 1974 over the projected life of the project, through FY 1979.

	<u>Dollar Equivalent (\$000)</u>
Personnel	1,702
Facilities	3,408
Commodities	498
Total	<u>5,608</u>

Personnel salaries include projections for personnel to be trained under project auspices, as described below. Contributions for facilities include the fair market value of land, and operation and maintenance costs borne by the Government of Laos. Commodity contributions consist of pharmaceutical supplies and related articles."

The FY 1975 MCH/FP Project Agreement had not been signed as of July 31, 1974. The Mission will notify AID/W as soon as it has been signed.

E. PROP REVIEW AND APPROVAL PROCESS

The integrated Laos MCH/FP project has come under considerable review at both the Mission level and the AID/W level, particularly since the fall of 1973. We anticipate that the new PROP will provide a vehicle for resolution of the several outstanding issues, all of which relate to the multi-purpose nature of the project in particular, and to the Agency's implementation of Section 104 of the FAA in general.

We feel that the Laos project, as now conceived, reflects the Congressional mandate of Section 104 and that appropriations under this section of the authorization would be the appropriate source of overall project funding, with the possible exception of funds for hospital wing construction and equipment. The mission, nevertheless, does not wish to prejudge the AID/W approval process, which will perforce include a resolution of the funding issue.

It may be useful to review the correspondence relating to this project which has transpired since late 1973 as background material for the review process. The following list identifies the most relevant material which has come to the attention of the Mission:

1. State 195757 - October 2, 1973
2. Vientiane 7409 - October 30, 1973
3. AIDTO A-1118 - November 6, 1973
4. Birnbaum to Kieffer, et. al. - November 23, 1973
5. State 236764 - December 4, 1973
6. Vientiane 0605 - January 24, 1974
7. Boynton to Ravenholt Trip Report - February 11, 1974

8. Kieffer to Birnbaum Memo - February 27, 1974
9. AIDTO A-230 - March 16, 1974
10. Kieffer to Nooter Memo - March 25, 1974
11. Sweet to Zimmerly Memo - March 29, 1974
12. Zimmerly to Kieffer Memo - April 9, 1974
13. Harvey (AA/LEG) to Mission Director (pp. 6-9) - June 4, 1974
14. AIDTO A-448 (pp. 20-23) - June 6, 1974
15. Cumminsky to Kieffer (Draft Agenda for Laos) - Undated
16. Unclassified Vientiane 5785 - July 24, 1974

In order to facilitate coordinated review of the project as an integrated whole by the several AID/W offices involved, and in anticipation of a continuing dialogue on this subject, the Mission will be most responsive to correspondence from AID/W which indicates a joint position through the use of such TAGS as "From Ravenholt and Zimmerly", or "From Nooter and Kieffer".

I. PROJECT IDENTIFICATION

1. Project Title		Appendix Attached	
Maternal and Child Health/Family Planning		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
3. RECIPIENT (specify)		2. Project No. (M. O. 1093. 439-11-570-081)	
<input checked="" type="checkbox"/> Country <u>Laos</u> <input type="checkbox"/> Regional _____ <input type="checkbox"/> Interregional _____		4. Life of Project	
		Begins FY <u>1969</u> Ends FY <u>1979</u>	
		5. Submission	
		<input type="checkbox"/> Original _____ Date	
		<input checked="" type="checkbox"/> Rev. No. 1, July 1, 1974 Date	
		Contr/PASA No. <u>439-851</u>	

III. ORIGINATING OFFICE CLEARANCE

1. Drafter	<u>Alan H. Mumm</u>	Title	Date
	<u>Alan H. Mumm</u>	MCH/FP Project Manager	<u>August 25, 1974</u>
	<u>Edwin McKeithen</u>	Assistant Program Officer	<u>August 25, 1974</u>
2. Clearance Officer	<u>Charles A. Mann</u>	Title	Date
	<u>Charles A. Mann</u>	US AID Director	<u>Aug 5, 1974</u>
1. Conditions of Approval			

2. Clearances

Bur/Off.	Signature	Date	Bur/Off	Signature	Date

3. Approval AAs or Office Directors

Signature	Date
Title	

4. Approval A/AID (See M. O. 1025.1 VI C)

Signature	Date
Administrator, Agency for International Development	

II. FUNDING (\$000) AND MAN MONTHS (MM) REQUIREMENTS

A. Funding By Fiscal Year	B. Total \$	C. Personnel		D. Participants		E. Commodities \$	F. Other Costs \$
		(1) \$	(2) MM	(1) \$	(2) MM		
1. Prior thru Actual FY 74	4,533	1,022	907	67	84	2,450	994
2. Oprn FY 75	1,975	316	306	27	26	830	802
3. Budget FY 76	1,949	309	304	23	18	977	640
4. Budget +1 FY 77	1,357	314	268	3	7	838	202
5. Budget +2 FY 78	1,265	177	20	2	6	929	157
6. Budget +3 FY 79	1,190	55	-	2	6	992	141
7. All Subq. FY							
8. Grand Total	12,269	2,193	1,805	124	147	7,016	2,936

Note: Figures include centrally funded commodities and USDH salaries funded under Operating Expenses

II. FUNDING (\$000) AND MAN MONTHS (MM) REQUIREMENTS

	G. PASA/CONTR.		H. Local Exchange Currency Rate: \$U. S. = 605 Kip* (U. S. Owned) *current rate		
	(1) \$	(2) MM	(1) US Grant Loan	(2) Coop Country	
				(A) Joint	(B) Budget <u>1/</u>
1. Prior thru Actual FY 74	1,500	1,895	70		815
2. Oprn FY 75	776	270	-		559
3. Budget FY 76	606	268	-		570
4. Budget +1 FY 77	159	268	-		579
5. Budget +2 FY 78	20	26	-		594
6. Budget +3 FY 79	-	-	-		611
7. All Subq. FY					
8. Grand Total	3,061	2,727	70		3,728

1/ Estimates for FY 75-79

I. PROGRAM GOAL

A. Statement of Goal

The goal of the MCH/Family Planning Program is two-fold:

1. To reduce the rate of population growth to a level that will promote the social and economic progress of the nation.
2. To reduce morbidity and mortality among the mothers and children of Laos.

B. Measurement of Goal Achievement

1. Reduction of the 1972 birth rate of 43/1000/yr.* to:

41 by the end of CY-74 (a 4.6% cumulative reduction)		
40 by the end of CY-75 (a 6.9%	"	"
39 by the end of CY-76 (a 9.3%	"	"
38 by the end of CY-77 (a 11.6%	"	"
37 by the end of CY-78 (a 13.9%	"	"
36.5 by the end of CY-79 (a 15.0%	"	"
22 by the year 2000 (a 50%	"	"

Means of verification: (1) Estimates based on program statistics; (2) Sample census data; (3) Samples Surveys; (4) Ministry of Public Health statistics; (5) Contraceptive import data.

2. 20% reduction of both infant and maternal mortality rates by the end of CY-79.

Means of verification: Fertility and mortality sample surveys

C. Assumptions Related to Achievement of Goal

1. Political dynamics of coalition government do not significantly impede project implementation.

*Population Reference Bureau Estimate

2. Motivation on behalf of Lao couples to adopt and continue contraceptive behavior.
3. Formal adoption by the RLG of the demographic goals of the project and continued promotion of activities to reach these goals.
4. Funding from other donors for the sample surveys necessary to provide data to determine goal achievement.

II. PROJECT PURPOSE

A. Statement of Purpose

(1) To establish basic maternal-child health and family planning services reaching 70% of the accessible population by the end of FY-79; and, (2) to create demand for these services among the target population.

B. Conditions Expected at the End of the Project

1. Capable administration of project activities by the Ministry of Public Health as evidenced by:

- 1.1 Adequate and timely delivery of supplies to service delivery outlets as indicated by maintenance of a four month inventory of contraceptive supplies throughout the delivery system.
- 1.2 Periodic preparation of accurate project reports and statistics.
- 1.3 Effective training courses conducted on a regular basis for the several levels of personnel involved in project implementation.
- 1.4 Availability of family planning and basic maternal child health services to 70% of the population.
- 1.5 95,000 eligible women practicing contraception:*

5% age 15-19

*Preliminary targets derived without benefit of adequate age distribution data and age specific fertility rates. If UNFPA sample census results provide reliable rates, these targets will be refined accordingly. Census results expected by December 1974.

14

15% age 20-24
25% age 25-29
30% age 30-34
25% age 35-

1.6 60,000 new acceptors in CY-1979 with a 12-month continuation rate of 56%.

Means of verification: All of the above to be determined from program statistics, Ministry of Public Health statistics, field inspections, spot checks, clinic records, sample audits, other donor records, population estimates, examination of warehouse and transportation documents, and evaluation of training programs.

2. Evidence of a 20% reduction in both maternal and infant mortality rates:

1.1 Means of verification: mortality and fertility sample surveys funded from other sources.

3. Nationwide application of an effective public information program by the RLG and other donor agencies:

1.1 Means of verification: Evidence of increasing levels of knowledge and utilization of project supported services resulting from public information activities as determined by field investigations and sample surveys.

C. Assumptions related to Project Purpose

1. Ministerial responsibilities delegated by the National Commission for the Promotion of Family Well-being will be carried out.
2. RLG will develop capability to administer the project.
3. External assistance to the RLG from all sources will be provided at adequate levels.

4. RLG training programs will produce sufficient numbers of qualified personnel to staff the expanding number of service outlets, and evaluative efforts can be properly staffed and conducted.
5. The political climate will continue to favor the expansion of MCH/family planning services.

III. PROJECT OUTPUTS

A. Outputs and Output Indicators

1. Service Availability

1.1 Number of MCH/Family Planning Service Outlets

<u>Sponsor</u>	<u>End of CY</u>						
	<u>73</u>	<u>74</u>	<u>75</u>	<u>76</u>	<u>77</u>	<u>78</u>	<u>79</u>
RLG	14	76	181	220	255	280	300
USAID National Health Development Project (1)	45	60					
OB Public Health (2) Field Teams	13	15	15	15	N/A	N/A	N/A
LFWA (3) (Estimates)	10	15	20	20	20	20	20
Other (4)	<u>9</u>	<u>9</u>	<u>N/A</u>	<u>N/A</u>	<u>N/A</u>	<u>N/A</u>	<u>N/A</u>
	91	182	216	255	275	300	320

Footnotes:

- (1) Will be incorporated into RLG System by end CY-75
- (2) Operation Brotherhood - USAID Contract Organization
- (3) Lao Family Welfare Association (IPPF)
- (4) Dooley Foundation, Asian Christian Service

1.1.1 Means of verification: Information to be gathered from the records of the RLG and participating agencies.

1.2 Proportion of the population with access to project services

	<u>By End of CY</u>						
	<u>73</u>	<u>74</u>	<u>75</u>	<u>76</u>	<u>77</u>	<u>78</u>	<u>79</u>
	29%	48%	58%	65%	69%	70%	71%

1.2.1 Means of verification: Estimates of the population served by service outlets.

2. Service Utilization

<u>Indicator</u>	<u>74</u>	<u>75</u>	<u>By End of CY</u>		<u>78</u>	<u>79</u>
			<u>76</u>	<u>77</u>		
Contraceptive Users	22,000	36,000	50,000	65,000	80,000	95,000
Percentage of eligible Population Enrolled	5%	7%	9%	12%	14%	16%
New Acceptors Per Year	17,000	26,000	35,000	44,000	52,000	60,000
First Year Continuation Rate	51%	52%	53%	54%	55%	56%

2.1 Means of verification: Analyze RLG and donor agency records and audits of clinic records.

3. Training

3.1 Standardized curricula prepared by June 1975 for all of the various levels of personnel to be trained

3.2 Personnel trained for family planning service delivery, supervision, and motivation:

<u>Type of Worker</u>	<u>Number to be trained Annually</u>						
	Thru <u>CY-73</u>	<u>CY-74</u>	<u>CY-75</u>	<u>CY-76</u>	<u>CY-77</u>	<u>CY-78</u>	<u>CY-79</u>
a. RLG							
Aux. Nurse Midwives*	130	62	15	-	-	-	-
Polyvalent Worker*	-	-	-	25	25	25	25
Graduate Midwives	39	15	15	15	15	15	15
Field Medics* (RLG and USAID NHD)	-	-	65	60	-	-	-
Field Super- visors*	20	37	20	20	20	20	20
*Project-funded Training							
b. USAID (National Health Development Local Hire Employees)							
Field Medics	20	-	-	-	-	-	-
Practical Nurse Midwives	25	15	15	15	-	-	-
c. LFWA							
Field Motivators	26	31	N/A	N/A	N/A	N/A	N/A
TOTAL	260	160	130	135	60	60	60

3.3 Other personnel trained in Family Planning as a part of their regular training curriculae

<u>Type Personnel</u>	<u>Number to be trained Annually</u>						
	Thru <u>CY-73</u>	<u>CY-74</u>	<u>CY-75</u>	<u>CY-76</u>	<u>CY-77</u>	<u>CY-78</u>	<u>CY-79</u>
a. RLG							
Physicians	20	-	20	20	20	20	20
Medical Assistants	26	30	30	30	30	30	30
Registered Nurses	69	30	30	30	30	30	30
Practical Nurses	100	50	50	50	70	70	70
Aux. Nurse Midwives	174	30	-	-	-	-	-
Polyvalent Workers	-	-	60	60	60	60	60
Graduate Midwives	39	15	15	15	15	15	15
Rural Midwives	202	-	10	-	20	20	20
TOTAL	630	155	215	205	245	245	245

b. Commission for the Promotion of Family Well-being

	To Date	<u>CY-74</u>	<u>CY-75</u>	<u>CY-76</u>	<u>CY-77</u>	<u>CY-78</u>	<u>CY-79</u>
	Military Personnel	-	500	2,000	N/A	N/A	N/A
c. LEWA							
Rural Midwives	80	15	N/A	N/A	N/A	N/A	N/A
Non-Medical Gov't Officials	78	80	20	20	20	20	20

d. USAID	<u>Thru</u> <u>FY-74</u>	<u>FY-75</u>	<u>FY-76</u>	<u>FY-77</u>	<u>FY-78</u>	<u>FY-79</u>
F. P. Administration Team	-	5	5	-	-	-
M. D. 's and Medical Assistants	32	-	-	-	-	-
MCH Nurses	39	-	-	-	-	-
Midwives	36	-	-	-	-	-
I. E. C.	2	-	-	-	-	-
Hospital Staff	43	-	-	-	-	-
Workshop Participants	4	-	-	-	-	-
Other		10	2.5	6	6	6

Means of verification: RLG, USAID, and external donor agency records.

4. Logistics and Supply

4.1 Completion of a comprehensive plan for integration of RLG and USAID medical logistics efforts by end of FY-75.

4.2 Complete integration of RLG and USAID medical logistics efforts by end of FY-77 with functional logistics capability by the RLG as evidenced by:

a. Order and delivery records analysis

b. Four-month level of contraceptive materials on hand in each service outlet

c. Regular and sufficient quarterly delivery of supplies and payroll

d. Less than 20% of project vehicles deadlined at any one time

Means of verification: records analysis and inspections

5. Public Information Activities

5.1 Information and/or service outlets operative in 20 major urban markets

5.2 Other specifics to be determined by the end of FY-75 with the assistance of a project-funded IEC consultant

5.3 Commission for the Promotion of Family Well-being

a. Family planning information and demonstration seminars for 2,500 military personnel by the end of FY-75 and possibly as many as 500 per year for several years thereafter.

b. 80,000 pamphlets and brochures printed in FY-74 with like numbers tentatively planned for future years (materials and printing primarily funded by USAID).

c. Appointment books, desk calendars, wall calendars, and posters are planned but specific quantities are not known at this time.

d. Other activities under consideration: Labels for rubber sandals, beer bottles, pencils, shopping bags, and match boxes; newspaper advertisements and articles; expanded radio program activities; training for personnel outside the health sector.

5.4 Lao Family Welfare Association

a. Twenty-six motivators trained to date with 31 to be trained end of FY-75 (two-week training course plus two weeks of supervised field work). No firm plans beyond FY-75 but this type of activity is likely to be continued.

b. I.E.C. Budget

<u>FY-73</u>	<u>FY-74</u>	<u>FY-75</u>
\$7,000	\$19,000	\$32,000

c. Audiovisual Public Information Programs

	<u>1973</u>	<u>1974 (1st Qtr.)</u>
Sessions	90	19
Attendance	12,000	6,500

d. Seminars/Lectures in CY-73

Twenty-one seminars or lectures reaching an audience of 3,000 people. No firm plans for the future but there has been a constant increase in the number of requests for both audiovisual and seminar/lecture programs.

e. Printed Materials Generated in 1973-74:

Posters	5,000
Pamphlets	10,000

f. Other Activities in Process or Being Planned:

Family planning T-shirts, bumper stickers and calendars. Family planning boat racing teams, radio shows (one-half hour, three times weekly in Vientiane at present with expansion planned) family planning quarterly newsletter, information along with three condoms inserted in boxes of local detergent, mobile display unit, information booths at fairs, information programs in temples.

5.5 USAID/Operation Brotherhood

Since 1971 the Operation Brotherhood field operations team has presented group lectures on family planning and related topics to over 13,000 people and has printed 3,000 posters or flip charts, many of which have achieved widespread distribution via the USAID refugee health project and RLG health facilities.

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5.6 RLG

Until now the Ministry of Health has not implemented any widespread public information projects except through its clinical facilities, where it has presented family planning and related information to over 100,000 women in CY-73 and probably close to 200,000 since January 1972.

6. Private Sector Activities in FP Service Delivery

6.1 To encourage private sector involvement, the project will offer free contraceptive supplies through private organizations to all physicians in private practice beginning in FY-75.

B. Assumptions Essential to the Realization of the Above Project Outputs

1. Adequate numbers of qualified trainees can be recruited to work in rural areas.
2. Technical advisory services and assistance from U.S.G. and other donors will be forthcoming as planned.
3. The RLG will provide the budgetary and administrative support required to achieve the projected manpower levels.
4. Personnel trained under project auspices will be employed in direct support of project activities.

IV. PROJECT INPUTS

A. U.S. Inputs	MM* Per Yr	(\$000)				
		FY75	FY76	FY77	FY78	FY79
1. Personnel						
a. American						
Population Officer	12	45.0	45.0	50.0	52.0	55.0
I.E.C. Advisor	12	50.0	50.0	50.0	50.0	-
Hospital Admin. Adv.	12	55.0	55.0	55.0	55.0	-
I.E.C. Consultant	2	9.0	-	-	-	-

*Man Months

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IV. PROJECT INPUTS (continued)

A. U.S. Inputs	MM* Per Yr	(\$000)				
		FY75	FY76	FY77	FY78	FY79
1. Personnel						
a. American (continued)						
Medical Logistics Consultant	2	9.0	9.0	9.0	-	-
Hosp. & Equip. Consultant	2	8.0	8.0	8.0	8.0	-
b. TCN						
2-Medical Maint. Tech.	24	10.0	12.0	12.0	12.0	-
OB Field Team	240	130.0	130.0	130.0	-	-
TOTAL PERSONNEL		316.0	309.0	314.0	177.0	55.0

2. Training	MM* Per Yr	(\$000)				
		FY75	FY76	FY77	FY78	FY79
Participant Training						
Family Planning Admin. Team US	15	22.5	22.5	-	-	-
Third Country (IEC Supervisors, Statisticians and Supply Officers - Avg. cost /MM:\$400.0)		4.5	1.0	2.5	2.5	2.5
TOTAL PARTICIPANT		27.0	23.5	2.5	2.5	2.5

3. Commodities	FY75	FY76	FY77	FY78	FY79
Contraceptives	134.0	147.0	168.0	218.0	270.0
Gen. Medical	514.0	540.0	645.0	695.0	705.0
Hosp. Equipment	110.0	209.0	-	-	-
Vehicles	5.0	8.0	12.0	2.0	2.0
GFM	50.0	60.0	-	-	-
Gen. Supplies	17.0	13.0	13.0	14.0	15.0
TOTAL-Commodity	830.0	977.0	838.0	929.0	992.0

*Man Months

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Other Costs	<u>FY75</u>	<u>FY76</u>	<u>FY77</u>	<u>FY78</u>	<u>FY79</u>
Transportation of Commodities	50.0	50.0	50.0	30.0	30.0
Operational Travel	6.0	6.0	6.0	6.0	6.0
Local Currency Costs	64.0	65.0	70.0	40.0	40.0
I. E. C.	30.0	30.0	40.0	50.0	50.0
MRO	12.0	12.0	13.0	13.0	9.0
Air Transport	20.0	20.0	15.0	10.0	-
Misc. Contract Services	10.0	10.0	8.0	8.0	6.0
L. P. Construction	600.0	-	-	-	-
Svkt. Construction	-	440.0	-	-	-
Rural Renovations	10.0	7.0	-	-	-
TOTAL OTHER COSTS	802.0	640.0	202.0	157.0	141.0

GRAND TOTAL 1,975.0 1,949.5 1,356.5 1,265.5 1,190.5

Five Year Total: 7737.0

B. Host Government Inputs

1. Personnel	Numbers of Personnel		(\$000)	
	<u>CY74</u>	<u>CY75-FY79</u>	<u>CY74</u>	<u>CY75-FY79</u>
MD's and Ass't. MD's	31	See Footnote	37	See Footnote
Nurses	145	1/	46	1/
Midwives	71		27	
Aux. Midwives	207		62	
Rural Midwives	167		12	
Admin. & Others	60		18	
			<u>202</u>	<u>1,300</u>

1/ No precise projections available; numbers expected to increase substantially through FY 79. Totals of CY74 and CY75-FY79 RLG inputs represent best estimates of host government contributions for purposes of calculating 25% contribution as required by Section 110(A) of FAA.

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B. Host Government Inputs (continued)

2. Service Facilities

	(\$000)	
	<u>CY74</u>	<u>Est. Total CY75-FY79</u>
a. Nat'l FP Center		
Land ^{2/}	202	909
Operation & Maint.	154	800
b. Pakse FP Wing		
Land ^{2/}	18	82
Operation & Maint.	96	600
c. Houei Sai FP Wing		
Land ^{2/}	12	50
Operation & Maint.	20	115
d. Rural FP Outlets (See output tables)		
Land ^{2/}	4	62
Operation & Maint.	14	190
	<u>520</u>	<u>2,808</u>

3. Training Facilities

Royal School of Medicine	10 ^{3/}	70 ^{3/}
Other Training Facilities	(Costs included in 1 and 2 above)	

4. Commodities

Pharmaceuticals & Equipment	50	325
Other	8	115
GRAND TOTAL ^{4/}	<u>790</u>	<u>4,818</u>

^{2/}Total land costs pro-rated over 5 1/2 year period from January 1974 through June 1979.

^{3/}Attribution of 20% of School of Medicine's budget related directly to MCH/FP instruction.

^{4/}For Section 110(A) determination, host government contribution to project from January 1974 through FY79 is \$5,608,000.

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C. Other Donor Inputs	<u>CY74</u>	<u>CY75</u>	<u>CY76</u>	<u>CY77</u>	<u>CY78</u>	<u>CY79</u>
1. Lao Family Welfare Ass'n.						
Commodities	24.0	26.0	N/A	N/A	N/A	N/A
I. E. C. Activities	20.0	32.0	N/A	N/A	N/A	N/A
Operating Expense	30.0	34.0	N/A	N/A	N/A	N/A
Total	<u>74.0</u>	<u>90.0</u>				
2. W. H. O.						
Advisors (five through 1976)	100.1		(W. H. O. inputs will be funded by U. N. F. P. A. starting in FY-75)			
Supplies and Equipment	10.0					
Other	<u>19.1</u>					
Total	129.2					
3. Asia Foundation						
Operating budget for the Commission for the Promotion of Family Well-being	13.6	N/A	N/A	N/A	N/A	N/A
4. UNICEF						
Construction of Facilities	180.0	180.0	N/A	N/A	N/A	N/A
Commodity support for the Dept. of MCH	11.0	14.0	N/A	N/A	N/A	N/A
Other Projects related to MCH/FP	27.3	27.5	N/A	N/A	N/A	N/A
Total	<u>218.3</u>	<u>221.5</u>				
5. IGCC - No information available on future plans; in the past has funded travel for seminars and training for Ministry of Public Health officials.						

6. UNFPA	<u>CY75</u>	<u>CY76</u>	<u>CY77</u>	<u>CY78</u>
Personnel				
Foreign Advisors (4)	120.0	120.0	120.0	120.0
Local Personnel	8.5	8.5	8.5	8.5
Training				
Fellowships	16.3	16.3	16.3	16.3
Incountry (80/yr.)	16.0	16.0	16.0	16.0
Commodities				
Contraceptives	25.0	25.0	25.0	25.0
Printing	11.0	11.0	11.0	11.0
Medical	5.5	5.5	-	-
Audiovisual Equip.	3.0	3.0	3.0	-
Vehicles	13.4	13.4	13.4	13.4
Office Equipment	1.5	-	-	-
Other	.5	.4	-	-
Other Costs				
Clinic renovations	8.0	5.0	5.0	5.0
Maint. & Oper. Exp.	6.0	10.0	10.0	10.0
Travel	.6	.6	.6	.6
Sundry	<u>2.4</u>	<u>2.4</u>	<u>2.4</u>	<u>2.4</u>
Total	248.7	237.1	231.2	228.2

D. Assumptions related to inputs:

1. USAID funding will be forthcoming in an orderly and timely manner.
2. Other donors will allocate their resources as planned.
3. RLG budget inputs will continue to grow at a rate sufficient to support project activities.
4. The RLG will carefully coordinate and manage all donor inputs.

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V. RATIONALE

Laos compares unfavorably with most of the developing countries by almost any yardstick of national development. It suffers from a static per capita income of \$60 - \$100 per year, and a crude rate of natural population increase of 2.5% per year, based on an estimated 1973 crude birth rate of 42 per thousand and a crude death rate 17 per thousand (Population Reference Bureau). Its age distribution is heavily weighted in favor of the young non-productive members of society--over half the population is estimated to be under the age of 15. Laos is at a further disadvantage because of the disruption caused by over twenty years of warfare. Casualties have been heavy on all sides, and a third of the population has been displaced by the hostilities. The losses in human resources have been accompanied by lost opportunities for economic development, and high levels of morbidity throughout the population have further decreased the effective manpower base of the country. And, while the population density is low, a large increase in arable land can be achieved only by developing marginally productive lands--a task that will require high capital inputs and result in even greater strain on an already burdened economy. Thus, the problem to be confronted is not population density per se but rather that of achieving a balance between the population growth rate and the resources that can be developed to support the population and assure social and economic progress. As a net importer of most consumer goods, including rice and other foodstuffs, and burdened with a population growth rate that will double the population every 28 years, Laos is faced with a population problem of great magnitude by every definition.

The contributions that the MCH/Family Planning Project can make to the national development of Laos can best be thought of in terms of the family on the one hand (micro level) and the nation on the other (macro level).

The Family (Micro) Level:

At the family level, the aim of the MCH project is to provide each family the means to determine the number and spacing of its children, and to contribute to reductions in the levels of mortality and morbidity which presently discourage family planning based on expectations of reasonable survivability.

From the point of view of an individual family the benefit of planning the number and spacing of births include a greater share of the family's

resources for each member, including better nutrition, housing, clothing, parental guidance, education, inheritance, and health care. The health of both mother and child is also affected by the number and spacing of births; and the family further benefits from the increased opportunity to work which fewer pregnancies afford the mother. The parents, of course, are acutely aware of the extra time, energy and resources required by each additional child; and this realization is reflected in preliminary surveys of Lao parents who reported their desire to limit the number of children they have. In a 1970 limited sample survey conducted in the village of Sikhay:

31% of those with 2 living children said they wished to have no more;

33% of those with 3 living children said they wished to have no more;

78% of those with 4 living children said they wished to have no more;

90% of those with 5 living children said they wished to have no more.

Yet, the average completed family size in Laos is greater than six children, a reflection of the inadequate availability of family planning services. The burden on each family is further increased by the current high rates of fetal wastage, and infant and maternal mortality and morbidity, many of which are directly related to large numbers of unplanned pregnancies.

The National (Macro) Level:

From the point of view of aggregate national development, the benefits of the population program are similar to those which accrue to the individual family, although they affect the nation in many other ways as well. In the first place, it is clear that there is no necessary contradiction between a growing population and growing national and per capita incomes; what is at issue is the encouragement of per capita income growth by population growth rates which lend support to national development programs rather than detract from them. Furthermore, it should be borne in mind that the population of Laos is bound to increase dramatically regardless of the effects of any conceivable reduction in the birth rate. To take an isolated example, the current generation of young parents aged 15 to 30 is only half as large as the group that will take their place ten years from now (who are currently aged 5 - 20), so that even a 50% reduction in the birth rate would not reduce the number of offspring generated by parents in the 15 - 30 age group of 1984. The choice lies between a population

that will double in size in less than 30 years, or one which will double in about 60 years; the RLG has opted for the latter goal, aware of the lesson of history that no country has ever modernized or reached an economically advanced position in the face of sustained high fertility levels.

The Dependency Burden

Laos presently suffers from one of the highest dependency burdens in Asia, that is, the number of young and old people who have to be supported by people in the productive age groups from 15 - 64. The nation, like the family, suffers from an extreme imbalance between those who produce and those who consume, except that the nation must provide a greater range of services to the people than each family can provide for itself. These national services, health and education, for example-- may properly be considered as investments in the human resources of the future, but they must be balanced against other priorities of national investment like roads and agriculture. The educational system of Laos will be directly affected by reductions in the dependency burden of the population. Over half the population aged 6 - 11 is now unable to even attend school due to a lack of facilities and teachers, and quality suffers while the struggle continues to provide the barest facilities to expanding classes.

A long term benefit of a decrease in the dependency burden will be an increase in per capita incomes. Experience in other countries suggests that if Laos is able to halve its population growth rate by the year 2,000, it should expect per capita incomes in that year to be significantly higher than had the growth rate continued unabated.

The growth of the labor force will remain unaffected for the next fifteen to twenty years and the lessened dependency burden placed upon the productive members of society should help to increase their productivity. In the longer run, the rate of growth of the labor force will tend to decrease, which will better enable Laos to establish satisfactory rates of employment and labor utilization and help avoid the masses of unskilled, unemployed people which characterize other developing countries.

Income Distribution

Reductions in the dependency burden should also help bring about a more equitable income distribution and spread the eventual fruits of

development more evenly throughout the population. In addition to the benefits of reduced family poverty and reduced unemployment which result from reduced dependency, the Lao population will also enjoy less aggravated pressures on land and less accelerated subdivisions of land into uneconomic parcels of inheritance. And as the marginal product of labor slowly rises relative to the marginal product of capital, the rewards to labor should rise proportionately to the returns on capital to reinforce the other income redistribution effects of lower dependency.

The RLG Approach

There are two salient characteristics of the RLG's approach to its population program that are worthy of special mention, and they both involve appropriate measures to avoid problems which have beset family planning programs in other countries. In the first place, the RLG Commission for the Promotion of Family Well-being is composed of the higher ranking civil servants in the Ministries of Interior, Social Welfare, National Education, National Economy, Religious Affairs, Information, Justice, and Plan, as well as the Ministry of Public Health. The broad composition of this Commission is a reflection not only of the support which the several governmental bodies can provide to the primary service delivery channel--the Ministry of Public Health--but also of the need to stimulate demand for family planning services through government-wide programs of information, education and communication, as well as the large need to establish certain levels of social and material well-being to encourage the voluntary reduction of family size. One of the characteristics of modern development has been that improvements in social and economic welfare have been closely related to reductions in birth rates. The contributing factors are many, and include the spread of education, increased age of marriage, greater employment opportunities, improved status of woman, perceptions of self-betterment, improved income distribution, and related cultural and political factors which make up the environment of successful development. Narrowly defined family planning programs per se are not enough to affect traditional attitudes about planning families.

The second salient characteristic of the RLG approach is its emphasis on the relationship between maternal and child health and family planning. This approach is based on the fact that reductions in the high infant mortality levels of Laos will allow for more predictable family planning and fewer pregnancies as a greater proportion of children survive to become productive members of the household. Furthermore, the health of children is directly related to the health of their mothers, and the timing and spacing of births is also highly correlated to the health of both mothers and children.

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Other countries have been able to provide family planning services by using the existing MCH system as a foundation for a delivery medium. Laos on the contrary, must strengthen and expand the delivery system at the same time that it develops its family planning program. While there does exist a skeletal MCH system, it cannot yet carry out traditional MCH responsibilities, let alone the administration of effective nationwide family planning services. A post-partum program, for example, can hardly be begun when most births occur in the complete absence of contact with an MCH infrastructure.

Thus, from the standpoint of the relationship between reduced childhood mortality and the consequent need for fewer pregnancies on the one hand, and the need to build a delivery mechanism adequate to the task of providing family planning services on a nationwide scale on the other, the RLG and AID have understood the need for developing a Lao National MCH System as a necessary condition for implementing the project. As a practical matter, the development of a separate family planning bureaucracy was viewed as neither desirable nor feasible when the problems of qualified personnel to staff the effort, and funds to support it, were considered.

VI. COURSE OF ACTION

A. Implementation Plan

The design of the MCH project reflects the fact that present conditions in Laos require that family planning services be an integral part of a maternal and child health care system, and that activities which go beyond family planning are required to effect desired changes in mortality, morbidity and fecundity. On the one hand, the project emphasizes the development of an MCH system as a delivery and support mechanism for the provision of MCH/Family Planning services; and on the other hand, the project supports the development of activities in the fields of information, education, communication, employment, nutrition, law, agriculture, economic planning, and other areas which affect knowledge, attitudes and practices with regard to family size; and which in turn affect the demand for family planning services.

The MCH project was initiated in February, 1969; activity through FY 1974 may be summarized as follows:

Training

Since the beginning of the project, 32 physicians and assistant physicians and 43 MCH hospital personnel, 36 midwives and 49 nurses have been trained in Thailand and the Philippines in family planning under the participant training auspices of the MCH project. An additional 58 nurse midwives have been trained in Thailand, 41 of these under the USAID Village Health Project and 17 under the Asia Foundation. Four of these participants were trained in the U. S., one of them in the field of information, education and communication (I. E. C.).

Under the activity of in-country training, 74 of 202 traditional rural midwives on the Ministry of Public Health payroll have been upgraded through in-service training programs, along with 39 graduate midwives and 14 chief nurses and nursing instructors. One hundred and seventy-four auxiliary midwives have received two-year training courses; and 33 of these have undergone additional training in family planning under the auspices of the local affiliate of the International Planned Parenthood Federation. This affiliate, the Lao Family Welfare Association, has conducted family planning training courses for 54 rural midwives, 5 practical nurses and 17 chiefs of provincial MCH centers in addition to 25 practical nurses and medics of the USAID Village Health Project. Each year, approximately 30 nurses and 30 assistant doctors are trained in the Royal School of Medicine where the polyvalent curriculum includes a strong MCH/Family Planning component in keeping with the importance of maternal and child care in the country's ordering of medical priorities. The school of medicine will graduate its first class of about 20 physicians in 1975.

Construction of MCH Facilities

The first major construction effort of the MCH project was completed in April 1972 when the MCH wing of the Ban Houei Sai Hospital was opened. The second and largest of the five major construction projects was dedicated in September 1973. The Mahosot complex is the National MCH and Family Planning Center with overall national responsibilities for program administration and planning, and provides a facility for developing demonstration activities, training programs and model service delivery clinics as part of its role as the national center.

Family Planning Service Delivery

The leading sector in the Lao family planning effort was long the local IPPF affiliate, the Lao Family Welfare Association. The

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official Lao Government family planning program has had such a late start that it is just now playing a major role in terms of service delivery. This has been a natural outcome of the lack of official policy until 1972 and a consequent reluctance by the Ministry of Public Health to act in the absence of a clear-cut government mandate. Nevertheless, through CY 1973, roughly twice as many family planning acceptors received their first contraceptive supplies from other agencies as they did from Ministry facilities. The family planning service delivery system which is evolving consists of both clinical and non-clinical components. As of July 1974, family planning services were available at all of the Ministry's 15 provincial hospitals, although many of these had only recently come on line, and only two were engaged in formal post-partum services. Fifteen smaller Ministry clinics in semi-urban areas were also providing family planning services, as well as three clinics operated by the local IPPF affiliate, the Lao Family Welfare Association. In the rural areas of Laos, family planning services were available at 21 Ministry clinics and four Lao Family Welfare Association clinics.

Additional outlets for delivery of family planning services were provided through the Public Health Field Operation Teams of Operation Brotherhood and through the rudimentary dispensaries of the National Health Development project. The mobile OB Teams were providing services in 15 rural areas; and the NHD dispensaries were covering an additional 44 more. As of mid-1974, free condom distributions had also begun throughout Lao Armed Forces installations.

The expansion of the service delivery network will continue to exploit existing clinical and non-clinical channels to the maximum extent possible while exploring new approaches to service delivery. Table 1.1 in the Project Outputs section above gives projections for the expansion of the delivery network through CY 1979. It should be noted that substantial growth in the number of outlets only began to take place in late CY 1973, and that the small number of acceptors through CY 1973 reflected the limited delivery network, although the rate of growth of new acceptors was quite high:

<u>CY</u>	<u>New Acceptors</u>
1969	290
1970	703
1971	1,467
1972	3,800
1973	7,052

Not included in these figures were the number of women who have purchased contraceptives directly on the open market and those who had visited family planning clinics in Thailand. These two sources have probably served a number of women equal to the official count above. Reports from Lao Customs will soon specifically identify contraceptive imports so that more reliable estimates can be made.

Roughly eight percent of Lao acceptors have chosen the IUD, 83% take the pill, and 9% use condoms and other methods. Continuation rates seem comparable to other programs but a new records system adopted by the RLG has not been operative long enough to make accurate assessments.

Advisory Services

Advisory services through FY 74 have been provided by three direct hire and one contract Americans, by American Hospital Association consultants, and by personnel from Operation Brotherhood, IPPF, Dooley Foundation and WHO. The direct hire Americans have divided their time among the major components of the project as follows: The MCH/FP nursing advisor has been in charge of the participant training programs for the project and has worked closely with the Lao Family Welfare Association. From FY 72 through FY 73 a USAID demographer was instrumental in shaping the national policy through the guidance he provided the Commission for the Study of Family Well-being, and played an important catalytic role in alerting key government officials to the significance of population questions for national development. The hospital administration advisor has overseen the major construction efforts underway and, in consultation with Ministry of Public Health counterparts, has provided advice on questions of administration and functional organization that have arisen during the phases of design, construction, and operation of the new facilities. A full-time population officer and project manager was assigned to the project in lieu of a demographer in May 1973.

The Current Program

A turning point occurred in the project on January 5, 1972, when the Royal Lao Government formally committed itself to a population

policy of reducing the birth and death rates in order to be "...more in harmony with the practical realities of the country in the fields of education, public health, employment, etc., for the socio-economic progress of the nation over the next 30 years..." The policy statement, Presidential Decree No. 03/PC, also established an implementing mechanism for the policy--the Commission for the Promotion of Family Well-being. Article 3 of the Decree states that:

"The Commission has as its purpose the implementation of the recommendations proposed by the Commission for the Study adopted on November 19, 1971, by the Government:

- a. through the reduction of the rate of mortality through the Kingdom.
- b. through voluntary family planning, so as to promote harmonious growth of the population and family well-being.

The recommendations referred to in the Decree imply a fifty percent reduction within thirty years of 1972 estimated birth and death rates of 43 and 18 per thousand, respectively.

The implementing body--the Commission for the Promotion of Family Well-being--is composed of the heads of the Ministries of Public Health, Interior, Social Welfare, National Education, National Economy (which includes Agriculture), National Information, Religious Affairs, Justice, and the Commission for the Plan. The membership of the Commission reflects the broadly based effort which the Royal Lao Government has undertaken as a result of the Lao policy-makers' understanding of the need to attack the problem from many different angles.

The full Commission is further divided into two Sub-Commissions:

- a. The Sub-Commission for Public Health
- b. The Sub-Commission for Coordination and Information.

This division of responsibility represents the RLG's awareness of the distinction between (a) the health system which acts as the primary delivery mechanism of family planning services and (b) the non-health components of the population program which consist of the broad range of economic, cultural, legal, social and attitudinal factors which affect (and are affected by) population phenomena.

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1. The Health System

Under the umbrella of the Health System, the contributions of the MCH/FP project will continue in the current program categories of training, the provision of advisory services and commodity support.

a. Training

Significant changes in the pattern of training occurred during FY 1974 as in-country facilities took over much of the training which has been provided outside of Laos, and as training programs commenced for a new category of health personnel, the polyvalent health worker. The establishment of this new category of health worker is a reflection of the Ministry's realization of the central role that integrated MCH and family planning services must play in the overall development of Laos' public health effort. Basic training will no longer be left up to the MCH service to carry out, but will be conducted by the School of Public Health, where MCH/FP related courses will become a larger part of the core curriculum for all students. Medical training in general will concentrate on the development of paramedical personnel and assistant physicians as a higher priority than the training of specialized physicians, and will emphasize polyvalent training in a variety of health fields including the central discipline of MCH/FP for all categories of health workers.

b. Advisory Services

The MCH project will continue to provide advisory services along the lines already established, with the addition of a full-time project manager who will also assume the responsibilities of the demographic/statistical advisor. The advisory services provided by WHO or UNFPA will continue to play a central role in the effective development of MOPH capabilities, and it appears likely that WHO will provide a full-time resident advisor in administration to the National MCH Center at Mahosot Hospital, in addition to advisors in the fields of nurse/midwife education and medical/paramedical curriculum development.

c. Commodity Support

USAID will continue to provide the greatest share of contraceptive supplies consumed in the program. In addition, a wide range of general medical supplies will be provided for use in MCH/FP

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training hospitals as well as service delivery outlets at all levels. In view of current economic realities, this support is deemed crucial to the eventual success of this integrated approach to providing both health and family planning services. To improve the RLG logistics capability, the project will fund a medical logistics consultant for three man-months per year, FY 75-77.

2. The non-health components of the MCH project

As outlined above, the RLG Commission for the Promotion of Family Well-being has established the distinction between the health and non-health components of the national population program.

One of the most important of these non-clinical components of the program is the input of information, education and communication resources that overcome the knowledge gap among both the providers and the recipients of family planning services, and that help to build a balance between "supply" on one hand and "demand" on the other. The importance of the non-health component in the RLG population program is indicated in the make-up of the Sub-Commission for Coordination and Information, in which coordination refers to the concerted efforts of the ministries to remain alert to the population aspects of their various activities, and in which information refers to the spread of knowledge about population and family planning matters throughout the country.

The Commission members are all high-ranking Secretaries of State or Directors General whose presence gives the necessary political support and policy direction to the RLG program. Beneath them at a secondary level sit the "promoters" in each ministry who are charged with carrying out the national policy as it affects their own ministries or departments. The idea behind the promoters is that they become the responsible people who tend to those aspects of the population program which apply to their particular sector.

The "promoters" are usually among the most talented of the high-ranking civil servants in their departments, and therein lies one of the difficulties which the program faces: The promoters are usually busy with the formal duties of their positions and sometimes do not have enough time to devote to their role as promoters of the national population program. Their preoccupation with other duties, along with the shallow

talent pool in many of the ministries, means that the population activities which require great amounts of time and energy are sometimes neglected because of the pressure of other work.

I. E. C.

This unavoidable neglect is most acutely felt in the field of Information Education and Communication (I. E. C.), where the preparation of information in materials, for example, is an enormously time-consuming task. Those officials in the Ministries of Information, Education, Interior, and National Economy, who have responsibility for curriculum development, information coordination, and materials production, for example, are pressed by the on-going requirements of their respective departments. However, they may remain aware of their roles as population promoters, and however much they may include population consideration in their regular activities, there remains the lack of unified, coordinated, consistent national population information program to complement the simultaneous development of the family planning service delivery mechanism in the health sector. There exist many part-time efforts in the field of I. E. C., but no full-time management of these activities and no coordinated marshalling of the various in-country and external resources which are currently available.

There is, thus, a pressing requirement for emphasis on I. E. C. activities. Project advisors will assist the various RLG promoters and the new full-time executive secretary of the Commission in carrying out their particular components of the overall information efforts, and to see that the different pieces are coordinated as one consistent whole. In addition, the project proposes to fund an I. E. C. specialist beginning in FY-75, and provide financial support for I. E. C. activities (see Input Tables).

Service Delivery

While the Sub-Commission for Coordination and Information suffers from excessive demands on the time of its members, the Sub-Commission for Public Health is composed of civil servants in the Ministry of Public Health whose normal working roles are virtually the same as those called for by the Sub-Commission. The problem here is not one of coordinating intra-ministry programs, but rather of developing the primary service delivery channel not only as an end in itself, but also to keep up with the demand created by the information program. The maternal and

child health section of the Ministry has begun upgrading its MCH centers and opening family planning clinics around the country at an accelerated pace since the beginning of 1976. National patient data forms have recently been standardized as the number of clinics has increased and the training programs for both students and in-service trainees have been upgraded to reflect the expanded roles of MCH personnel.

The Ministry of Public Health permits nurses and auxiliary midwives to prescribe contraceptive pills on the basis of a simple diagnostic checklist which screens out those women who need to see a physician before taking the pill. Women who pass the screening tests may be prescribed pills directly by the nurses. Two other USAID-supported programs--the Village Health Project and Operation Brotherhood--have expanded the MCH/FP components of their programs and have enlarged their delivery channels in the areas that they serve. Both of these projects provide services utilizing personnel with only 6 - 12 months of medical training.

The Lao Family Welfare Association moved into new and expanded quarters during 1973 and has initiated pilot projects directed toward refugee populations.

MAJOR PRECONDITIONS NEEDED TO ACHIEVE THE PROJECT PURPOSE

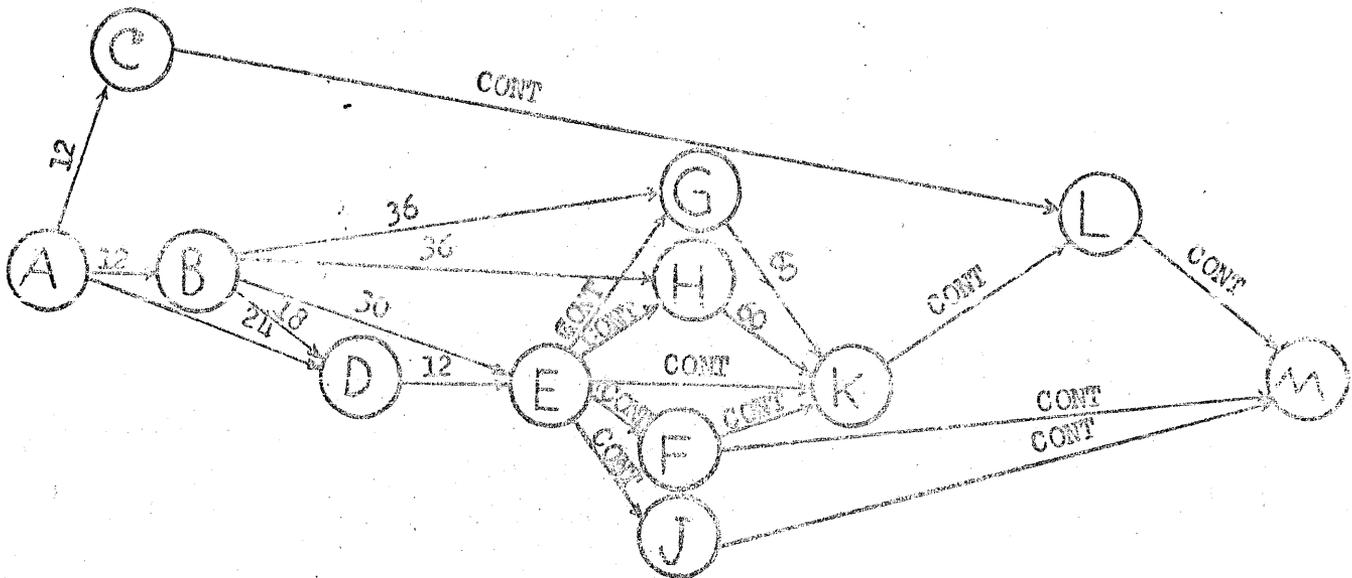
The major preconditions which affect the prospects of the MCH project all relate to central questions of political commitment by the RLG and continued progress toward a political reconciliation. The nature of the changes in the composition of the Lao Government in general and the Ministry of Public Health in particular are not well defined as of this writing, and it appears likely that the policies and administrative practices of the Ministry may be more strongly affected by the political left than has been the case since the beginning of the MCH project in 1969. It is probable that socialist influences of the Lao Patriotic Front will increase under the coalition government.

It is unlikely, however, that these socialist influences will decrease the commitment of the Provisional Government of National Union to the national MCH/FP program, given the high priorities of most socialist countries to similar programs. It is also unlikely that increasing socialist influences will force reductions in U.S. bilateral assistance to the Lao Government.

The major preconditions affecting the outcomes of the project, therefore, relate less to the political composition of the Lao Government than to the smoothness with which political reunification is achieved, and to continued commitment on the part of the PGNU to the objectives of the project.

IMPLEMENTATION PLAN

FY 69 FY 79



STEPS	ACTIVITIES	DESCRIPTION	RESPONSIBLE AGENT	TIME (MONTHS)
1	A-B	Analysis of Lao need for MCH services	USAID/MOPH	12
2	A-C	Establishment of private IPPF Clinic	Private	12
3	A-D	Analysis of Lao need for family planning, leading to the creation of the Committee for the Study of Population and Family Well Being	USAID/RLG	24
4	B-G	Training of MCH personnel in initial MOPH MCH program	USAID/MOPH/ Private	36
5	B-H	Implementation of initial MOPH MCH program in existing physical facilities	MOPH	36
6	B-D) B-E)	MOPH leadership in population study and policy determination	MOPH	18 36
7	D-E	Adoption of Pop/FP policy by RLG and establishment of Commission for the Promotion of Family Well Being	USAID/MOPH	12
8	E-F) E-G) E-H) E-J) E-K)	Coordination by RLG Commission of major RLG elements affecting population sector	RLG	Cont.
9	H-K	Construction and renovation of MOPH/FP facilities	USAID/RLG	60
10	G-K	Training of Polyvalent MCH/FP personnel	USAID/RLG/ WHO/Private	60

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STEPS	ACTIVITIES	DESCRIPTION	RESPONSIBLE AGENT	TIME (MONTHS)
11	F-K	I.E.C. activity increases demand for MCH/FP services	USAID/RLG/ WHO/Private	Cont.
12	C-L) K-L)	Delivery of MCH/FP services	MOPH/ Private	Cont.
13	J-M	Progress in national development in areas which contribute to accelerated demographic transition	All Agents	Cont.
14	F-M) L-M)	Attainment of program health and demographic goals	All Agents	Cont.

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LOGICAL FRAMEWORK

Narrative Summary	Indicators	Means of Verification	Assumptions
<p>Program Goal:</p> <ol style="list-style-type: none"> 1. Reduction of the population growth rate. 2. Reduction of infant and maternal mortality 	<ol style="list-style-type: none"> 1. 15% reduction of birth rate by 1979. 2. 20% reduction of IMR and MMR by 1979. 	<p>Project service statistics, sample surveys, sample census, Ministry statistics, contraceptive import data.</p>	<p>See Page 1</p>
<p>Project Purpose:</p> <ol style="list-style-type: none"> 1. Develop capability within the RLG to provide adequate MCH/FP services and to mount an IEC effort that successfully motivates couples to use project services 	<p>EOPS:</p> <ol style="list-style-type: none"> 1. Capable admin. of project activities. <ol style="list-style-type: none"> a. Reports and statistics b. Logistics and supply c. Effective and appropriate training. d. Services available to 70% of population e. Contraceptive utilization targets achieved. 2. Nationwide application of effective I. E. C. activities 	<p>Program statistics, MOPH statistics, field inspections, audits of field records, examination of warehouse and transportation documents, evaluation of training courses, evaluation of IEC efforts</p>	<p>See Page 3</p>
<p>Outputs:</p> <ol style="list-style-type: none"> 1. Service availability 2. Service utilization 3. Training outputs 4. Logistics and supply 5. I. E. C. 6. Private sector involvement 	<ol style="list-style-type: none"> 1. By 1979: 320 service outlets serving 70% of population. 2. By 1979: 95,000 current users; 60,000 new acceptors, 56% 1st yr. continuation rate. 3. See output tables. 4. See output tables. 5. To be determined by IEC Consultant 6. Private M. D. and non-clinical distribution. 	<p>RLG and donor agency records, field trials and sample surveys, acceptor audits, population estimates.</p>	<p>See Page 11</p>

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LOGICAL FRAMEWORK (continued)

Narrative Summary	Indicators	Means of Verification	Assumptions
<p>Inputs:</p> <ol style="list-style-type: none"> 1. RLG 2. USAID 3. IPPF 4. UNFPA 5. Asia Foundation 6. ISCC 	<ol style="list-style-type: none"> 1. Budget, facilities, personnel, operating expense. 2. Advisors, training, commodities 3. Services, I. E. C. Training 4. Advisors, training, commodities, construction 5. Budget - National FP Commission. 6. Travel 	<p>RLG and Donor Agency Reports and Records</p>	<p>See Page 16</p>