PD-RAF-122

386-0486

386-0468004201

AGENCY FOR INTERNATIONAL DEVELOPMENT

Integrated Rural Health & Population Project

PROJECT PAPER

AUGUST 1980

USAID/INDIA

AGENCY FOR INTERNATIONAL DEVELOPMENT

PROJECT DATA SHEET

1. TRANSACTION CODE: A (A = Add, C = Change, D = Delete)

Amendment Number

DOCUMENT CODE: 3

2. COUNTRY/ENTITY: INDIA

3. PROJECT NUMBER: 386-0468

4. BUREAU/OFFICE: ASIA 04

5. PROJECT TITLE (maximum 40 characters): Integrated Rural Health & Population

6. PROJECT ASSISTANCE COMPLETION DATE (PACD): MM 09 DD 30 YY 85

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

A. Initial FY 80 B. Quarter 4 C. Final FY 82

8. COSTS ($000 OR EQUIVALENT $1 = Rs.8.00)

A. FUNDING SOURCE	FIRST FY 80 B. FX	C. L/C	D. Total	LIFE OF PROJECT E. FX	F. L/C	G. Total
AID Appropriated Total		23,700	23,700		40,000	40,000
(Grant)	( )	(23,700)	(23,700)	( )	(40,000)	(40,000
(Loan)	( )	( )	( )	( )	( )	(
Other U.S. 1.						
Other U.S. 2.						
Host Country		14,700	14,700		24,745	24,745
Other Donor(s)						
TOTALS		38,400	38,400		64,745	64,745

9. SCHEDULE OF AID FUNDING ($000)

A. APPROPRIATION	B. PRIMARY PURPOSE CODE	C. PRIMARY TECH. CODE 1. Grant	2. Loan	D. OBLIGATIONS TO DATE 1. Grant	2. Loan	E. AMOUNT APPROVED THIS ACTION 1. Grant	2. Loan	F. LIFE OF PROJECT 1. Grant	2. Loan
(1) HF	B530	510				9,900		26,200	
(2) PN	B440	440				13,800		13,800	
(3)									
(4)									
TOTALS						23,700		40,000	

10. SECONDARY TECHNICAL CODES (maximum 6 codes of 3 positions each): 430 | 450 | 530 | 580

11. SECONDARY PURPOSE C

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

A. Code	BR	BRW	EQTY
B. Amount	25,000	15,000	20,000

13. PROJECT PURPOSE (maximum 480 characters)

1. To improve access to health and family planning services that promote fertility and mortality reduction.

2. To improve and expand the services and support systems of the GOI Model Health Plan.

14. SCHEDULED EVALUATIONS

Interim MM 5 YY 83 | MM YY | Final MM 9 YY 85

15. SOURCE/ORIGIN OF GOODS AND SERVICES

[X] 000 [ ] 941 [X] Local [ ] Other (Specify)

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

17. APPROVED BY

Signature: Priscilla M. Boughton

Title: Priscilla M. Boughton, Director, USAID/India

Date Signed: MM 05 DD 23 YY 80

18. DATE DOCUMENT RECEIV IN AID/W, OR FOR AID/W DO MENTS, DATE OF DISTRIBUT: MM 08 DD 08 YY 80

PROJECT PAPER

INTEGRATED RURAL HEALTH AND POPULATION

		Page Number
PART I	SUMMARY AND RECOMMENDATIONS	1
PART II	PROJECT BACKGROUND AND DETAILED DESCRIPTION	
	A. Background	5
	B. Detailed Project Description	10
PART III	PROJECT ANALYSIS	
	A. Services	23
	B. Support Systems	25
	C. Construction	27
	D. Financial Analysis and Plans	28
	E. Economic Analysis	32
	F. Social Soundness Analysis	33
PART IV	PROJECT IMPLEMENTATION PLAN	
	A. Administrative Arrangements	34
	B. Implementation Plan	36
	C. Evaluation Plan	37
	D. Conditions and Covenants	37

ATTACHMENTS

A. PID Approval Cable
B. 611 (e) Certifications
C. Draft Project Authorization
D. Draft Project Description for Grant Agreement
E. Statutory Checklists - 5C(2) and 5C(3)
F. Logical Framework

Note: Annexures referred to in the text are in a separate volume.

ABBREVIATIONS

ANM	-	Auxiliary Nurse Midwife, now designated as Female Multipurpose Worker (FMW)
BEE	-	Block Extension Educator
CBR	-	Crude Birth Rate
CDR	-	Crude Death Rate
CDSS	-	Country Development Strategy Statement
CHV	-	Community Health Volunteer
DANIDA	-	Danish International Development Agency
DMEIO	-	District Mass Education & Information Officer
DT	-	Diptheria and Tetanus Immunization
DPT	-	Diptheria, Whooping Cough and Tetanus Immunization
EE	-	Executive Engineer
FMW	-	Female Multipurpose Worker
GOI	-	Government of India
HA(F)	-	Health Assistant (Female)
HA(M)	-	Health Assistant (Male)
IAS	-	Indian Administrative Service
IEC	-	Information, Education, Communication
IUD	-	Intra Uterine Device
LHV	-	Lady Health Visitor, now designated as HA(F)
MCH	-	Maternal & Child Health
MOHFW	-	Central Ministry of Health & Family Welfare
MMW	-	Male Multipurpose Worker
NORAD	-	Norwegian Agency for International Development
ODA	-	British Overseas Development Agency
PHC	-	Primary Health Center
PHN	-	Public Health Nurse
PP	-	Project Paper
PVO	-	Private and Voluntary Organization
PWD	-	Public Works Department
RFWC	-	Rural Family Welfare Center
RHFWTC	-	Regional Health & Family Welfare Training Center
UNFPA	-	United Nations Fund for Population Activities
UNICEF	-	United Nations Childrens' Fund
WHO	-	World Health Organization

INDIAN TERMS

BLOCK	-	Community Development Block - lowest administrative unit within a district
CRORE	-	10,000,000
DAI	-	Traditional Birth Attendant
LAKH	-	100,000
PANCHAYAT	-	Elected body of the village
TALUKA	-	An administrative unit within a district, above the block but below the district.

The boundaries shown do not imply any judgment on the part of the U.S. Government on the legal status of any territory or any endorsement or acceptance of such boundaries.

PART I - SUMMARY AND RECOMMENDATIONS

A. GRANTEE AND IMPLEMENTING AGENCY

The Grantee will be the President of India. The implementing Agency will be the Ministry of Health & Family Welfare.

B. GRANT

The grant amount is expected to be $40 million, of which $23.7 million would be provided in FY 80, $9.4 million in FY 81 and $6.9 million in FY 82.

C. PURPOSE

The purposes of the grant are to (1) improve access to health and family planning services that promote fertility and mortality reduction, and (2) improve and expand the services and support systems of the Government of India's (GOI) Model Health Plan.

D. THE PROJECT

The Project will assist the GOI implement its Model Plan for basic health and family planning services in 13 districts, selected on the basis of economic and health related "backwardness" criteria, in five states (Maharashtra, Gujarat, Punjab, Haryana and Himachal Pradesh). Project outputs will include (1) additional trained workers, (2) additional service facilities and quarters constructed, (3) additional person-years of work, (4) improved and expanded services, (5) improved and expanded training support, (6) improved and expanded communications support, (7) improved and expanded existing service facilities, and (8) improved and expanded management support. Project inputs include technical and managerial skills of Indian institutions and Indian professionals and $64.75 million in financial input of which USAID would contribute $40 million. Due to the construction component and time required for management systems development, a five year disbursement period will be necessary.

E. OTHER DONORS

World Bank, the United Nations Fund for Population Activities (UNFPA), the Danish International Development Agency (DANIDA), and the British Overseas Development Agency (ODA) are financing or are in the process of concluding arrangements for financing, similar projects in 33 districts in seven states. The World Health Organization (WHO), UNICEF (United Nations Childrens Fund), and the Norwegian Agency for Development (NORAD) are providing support for national level health and family planning programs.

F. DISCUSSION OF PROJECT ISSUES

The principal issues raised by AID/Washington during the Project Identification Document (PID) review in June of 1979 were: (a) the effectiveness of the community health volunteer (CHV) scheme and progress to date in project areas; (b) whether construction of facilities is necessary to improve CHV effectiveness; (c) the possibility of loan funding rather than grant funding; and (d) the inclusion of a laparoscope program and/or private and voluntary organizations (PVO's) as part of the Project. Issues raised during the Project Paper (PP) design process (including the September 1979 design team visit) included: (e) adequacy of the service packages and organization of care for effective fertility and mortality reduction; (f) use of the government system by women and children, particularly from poor families; (g) the adequacy of contraceptive supplies at PHC's, subcenters, and in the village; (h) weaknesses in planning, evaluation, and training skills; (i) building quality and the use of local materials and labor to reduce construction costs; and (j) building maintenance. The status of project issues is as follows:

a) The CHV scheme is effective for fertility and mortality reduction if it is an extension of an organized system of care. It would be improved by having more females and improving the training programs. Considerable progress has been made in the implementation of the scheme in all the states, except in Punjab where no CHVs will be used. (see Part III : A and B)

b) Construction of facilities is necessary to improve CHV effectiveness as the CHV's skills are limited and must be supported by an organized system of care. (see Part III:A) An organized system of care requires workspace with privacy, lighting and adequate ventilation. To attract and retain female workers, secure and private living space is necessary. (see Part II: B2)

c) The possibility of loan funding was considered during project development. It was felt that grant assistance was both appropriate and necessary. All other bilateral assistance to the Model Plan is also grant financed.

d) A separate agreement for the supply of laparoscopes and the training of Indian obstetrician-gynecologists in laparoscopy has been reached. The program is now being reviewed due to A.I.D. legal/administrative discussions about PD-70. The inclusion of private and voluntary organizations under this grant was discussed with the GOI and it was felt that this would unduly complicate project design.

e) The service packages and organization of care of the model plan are adequate to effectively reduce fertility and mortality although the mortality reduction potential might be improved if selected services were added to the system. (see Part III and Annex 1).

f) The use of the government health system by women and children, particularly from poor families, may be less than desirable. (see Part III:F). The project will monitor use of services for these groups on a priority basis, (see Part II:B3) and will conduct research and/or innovative activities if utilization is low. (see Part II:B3).

g) A supply and resupply system exists that provides PHCs, subcenters and trained villagers with contraceptive supplies and equipment including IUDs, oral pills, condoms, diaphragms, and jellies (see Part II:A2). In the past, there have been supply problems, particularly at the remote units. At the present time, neither the GOI nor USAID can accurately say which specific contraceptive supplies and equipment are in short supply or out-of-stock relative to current or projected demand in different districts or groups (see Part III:B3). The adequacy of contraceptive supplies and equipment will be assessed during the baseline survey for each district and group (see Part IV:C). Special attention will be given to strengthen the prediction of contraceptive demand (see Part II:B3). By the end of the first year of project, critical contraceptive supply and equipment needs relative to current or projected demand will have been determined and plans made to make needed items available on a priority basis (see Part IV:B). By the end of the second year of the project, supply and equipment system improvements will have occurred so that needed items are usually available. (see Part IV:B).

h) Weaknesses in planning and evaluation skills will be improved during the project as will weaknesses in training. (see Part II:B3).

i) Construction quality was assessed during project development and was found to be generally satisfactory. GOI policy is to use local materials to minimize costs. Contractors, registered by the states, use local labor in building construction. (see Part III:C).

j) Maintenance of public buildings is a general problem, but assurances have been given that buildings will be maintained adequately. (see Part III:C).

G. BENEFICIARIES

This Project will benefit the rural poor in economically disadvantaged districts with relatively poor health status. Approximately 2.7 million families are expected to benefit from the Project at a cost to AID of $14.80 per family.

H. STATUTORY CRITERIA

The grant meets all applicable statutory criteria. A negative environmental determination was made at the time of the PID approval.

I. RECOMMENDATION

The Project is technically, financially, and socially sound and a grant of $40 million should be approved for the Project to be disbursed within five years from the date of the Project Agreement between the Government of the United States of America and the Government of India. Justification for a five year disbursement has been provided to Congress.

PART II - PROJECT BACKGROUND & DETAILED DESCRIPTION

A. BACKGROUND

1. Demographic, Fertility and Health Situation

a. Demographic Situation

India, with a population now exceeding 650 million, is the second most populous country in the world. Since India gained Independence in 1947, its population has almost doubled. Currently, it is growing at a rate of about 1.91% per year, which is moderate in comparison with the other countries of the region: Bangladesh, 2.4%; Iran, 2.6%; Nepal, 2.6%; Pakistan, 3.0%; Sri Lanka, 2.0%; Thailand, 2.4% (all 1977 figures). However, it is the magnitude of absolute growth -- presently about 13 million a year -- together with a significant proportion of people below the poverty line and pressure on resources which add to the problems of economic development in India.

About 80% of the Indians are rural and live in over 575,000 villages. The rate of urbanization is low--less than 2% per decade. Forty-one percent of the population is below the age of 15. World Bank projections show an expected range of population from 859 million to 921 million by the year 2001.

b. Fertility Situation

The Crude Birth Rate (CBR) is estimated at 33.2 currently. However, there is considerable variation in birth rates by state. In general, states in the southern, western, and northwestern parts of the country have lower birth rates than those in the central and eastern regions. The birth rate varies from 25.2 in Kerala to 40.4 in Uttar Pradesh.

The CBR in India has been dropping since the mid-1960's. It is officially estimated that 22% of eligible couples were effectively protected in 1979. Key indirect indicators of declining fertility, such as age at marriage and female literacy, are also improving.

c. Health Situation

While India had an overall Crude Death Rate (CDR) of 14.1 and an Infant Mortality Rate (IMR) of 129 in 1978, there is considerable variation within the country. Kerala is, again, most outstanding with a CDR of 7.0 and an IMR of 56. Central region states such as Uttar Pradesh, Bihar and Madhya Pradesh have the highest death rates--for example, Uttar Pradesh has a CDR of 20.2 and an IMR of 178.

India not only has much higher death rates but also a very different distribution of deaths from a developed country. Fifty five per cent of all deaths are in children under five; 30% in children under age one year; and about 17% in children under one month of life. In the USA, about 2.7% of all deaths occur in the 0-4 age group! Most deaths in the first month of life are due to tetanus, respiratory infections, septicemias, or to birth injuries. Most of the babies who die are low birth weight. Later on, diarrheas, measles, respiratory infections, diptheria, and whooping cough cause most of the deaths. Many of these dying children are also malnourished.

Although national data on mortality and morbidity of the rural poor is not readily available, indirect measures support the assumption that they suffer excessive amounts of death and disease. The rural CDR exceeds the urban CDR by 65% and the rural IMR exceeds the urban IMR by 74%.

More detailed analysis of the demographic, health and nutrition conditions in India can be found in the FY 82 Country Development Strategy Statement for India (CDSS).

2. GOI Policies and Programs

a. History of Family Planning and Health Program in India.

India has one of the oldest officially sponsored family planning programs in the world. Introduced in 1952 as an integral part of the country's economic and social development plan, the family planning program has made substantial progress. Over 31 million sterilizations and 8 million IUD insertions have been performed, besides enrolling over 3 million conventional contraceptive (chiefly condom) users.

Providing basic health care to all its citizens has been a major objective of the Indian Government ever since the country's Independence in 1947. Since then, the Government has established an impressive number of 5,400 primary health centers (one in each development block covering a population 80 to 100,000) and some 40,000 subcenters (one for every 10-12,000 population) throughout the country. In addition, a vast array of hospitals, dispensaries, clinics and other medical facilities, including 106 modern medical colleges, have been set up during the same period.

Yet there is room for improvement as there are significant differences in the availability of services and facilities between the rural and urban areas. It is estimated that nearly two-thirds of all inputs in the health field are currently deployed in the urban areas where only 20% of the population live. In the rural areas, it has been felt that the primary health centers and subcenters, while serving the population residing close by the centers, have not been sufficient to allow the majority of the population to benefit from their services.

b. Family Planning Policy

Since 1977 the family planning program in India has been guided by a comprehensive Population Policy (see Annex 1). Besides ruling out all forms of compulsion or coercion in the field of family planning, the following approaches have been emphasized: (a) promotion of all methods of contraception with equal emphasis so that each family may choose the method most appropriate to it; (b) integration of family planning with basic health services, particularly for mothers and children, into a "family welfare" program; (c) direction of the program towards those under-served, mainly in the rural areas; (d) expansion and redirection of the program's motivational activities from heavy reliance on mass media to an interpersonal and extension approach; (e) encouragement of participation by the community and by voluntary bodies; (f) establishment of village level, voluntary health workers and intensification of the dai (traditional birth attendent) training program, and (g) involvement of all departments of Government in the program. A new Five Year Plan for 1980-85, now under preparation, is expected to continue to place the same high priority on family planning.

c. Health Policy

The GOI has formulated a draft National Health Policy (see Annex 2) keeping in view the Alma Alta goal of "Health Care for All by the year 2000", to which India is a signatory. The draft policy lays considerable emphasis on preventive and promotive aspects of health care; greater decentralization of services; self-reliance through greater transfer of skills to and participation by the community and the development of an effective primary health care system which would ensure : (i) a greater awareness among the community and population of the health problems and ways to tackle them at their own levels; (ii) intervention at the lowest practicable levels by a worker more suitably trained; (iii) optimal utilization of knowledge and expertise by higher level technical experts by the health workers, physicians or specialists; and (iv) increasingly less dependence on hospitals and thus optimal utilization of such facilities for cases where they are actually needed .

d. The Model Plan for Rural Family Planning and Health Services

Following the precepts of the population policy and draft health policy, the GOI has developed its "model plan" for rural family planning and health services. This model plan has become part of a multisector National Minimum Needs Program. The model plan has been developed to implement the policy directives on a nationwide basis over a ten year period. In selected backward and under privileged areas of the country, the model plan is to be implemented in five years using external donor assistance (see Annex 3 for the donor-assisted model plan). The plan is based on the model shown below for organization of services in rural areas.

MODEL FOR INTEGRATED SERVICES IN RURAL AREAS

Level of Care	Providers	Population Served
Village	CHV, trained dai	1,000 people
Several villages(3-8) via subcenter	Female Multipurpose Worker (FMW) and male multipurpose worker (MMW)	5,000 people (3,000 people in tribal and hilly areas)
Community development block via Primary Health Center (PHC)	doctors, Lady Health Visitors (LHVs), FMWs Health Assistants (HAs)	100,000 people
Upgraded PHCs/Sub-district hospitals	Specialist doctors, general doctors, nurses	variable but about 300,000-400,000 people
District Hospitals	Specialist doctors, general doctors, nurses	million people plus

The basic structure of the model plan has been carefully developed by the GOI over the past several years. The main objectives of the plan are (1) accelerate and complete infrastructure facilities in selected backward and deprived districts within the next five years or so, (2) improve and expand the availability of basic health and family planning services in these districts so as to provide such services as close to the doors of the people as possible; (3) ensure quality services by improving and strengthening the skills of various categories of workers, and (4) encourage community participation so as to ensure optimal utilization of the facilities and services. The ultimate goal, of course, is to reduce fertility and mortality, particularly infant and young child and maternal mortality.

The service systems of the model plan are supported by training, communications, and management systems. Basic training for village-level workers occurs at PHC's for FMW's at FHW (ANM) Training Schools, for MMW's at PHC's, for LHV's at LHV or ANM Training Schools. Continuing education occurs at PHC's and Regional Family Training Centers. Trainers are trained at Regional Family Planning Training Centers or at the Central Training Institutes. The communications support system formally begins at the PHC (block level) where there is Block Extension Education Office. This office is supervised by a District Mass Education and Media Office which is in turn supervised by a State Mass Education and Media Office. The management support system functions through the PHC, district, and state for general administration, personnel management, supervision and monitoring, finance, and evaluation. The logistics system supports the service workers as follows: CHV's and subcenters routinely get supplies monthly at the PHC; PHC's routinely get supplies quarterly at the district supply office, and districts routinely receive supplies quarterly from state or regional depots. Service units may place special orders more frequently subject to their overall budget allocation.

The GOI has identified 46 districts in 12 states for implementation of the model plan A number of multilateral and bilateral donors are already supporting the Plan in several of these districts and states.

3. Linkage of Project to AID Development Strategy

The USAID/India development strategy for India, as enunciated in the Country Development Strategy Statement of India - FY 1982-86 identifies fertility and mortality reduction programs as high priority programs for AID support in India.

4. Other Donor Assistance

The GOI has completed or are in process of concluding arrangements for financing negotiations with the World Bank, the United Nations Fund for Population Assistance (UNFPA), the Danish International Development Agency (DANIDA), the British Overseas Development Agency (ODA) for implementation of the model plan in 33 districts in seven states. UNFPA will assist in nine districts in Bihar and Rajasthan; DANIDA in ten districts in Madhya Pradesh and Tamil Nadu ($40 million) and ODA in five districts in Orissa ($23 million). These projects are expected to begin in mid-1980.

In addition, WHO, and UNICEF are supporting specific national level programs and the Norwegian Government (NORAD) is financing a further expansion of the Postpartum Family Planning Program to cover sub-district hospitals and institutions.

5. Previous AID Assistance

AID was a major supporter of GOI health and family planning programs from 1952 to 1972. Its support has included (i) control of communicable diseases, particularly malaria, (ii) medical and nursing manpower training, and (iii) expansion and strengthening of family planning delivery services. AID contribution totalled $135.2 million during the above period.

6. Project States and Districts

The Project will be implemented in 13 rural and backward districts in five states: two districts each in Maharashtra (Osmanabad and Parbhani) and Gujarat (Bharuch and Panchmahals), and three districts each in Punjab (Bhatinda, Faridkot and Sangrur), Haryana (Bhiwani, Mohendergarh and Sirsa), and Himachal Pradesh (Hamirpur, Kangra and Sirmur). The districts were selected by the States and endorsed by the GOI on the basis of certain economic and health-related criteria. They include : (i) high proportion of rural population, (ii) high proportion of economically weaker and backward sections of the society, (iii) lack of adequate health and family planning infrastructure facilities, (iv) high birth rates and (v) high infant mortality rates. (For district profiles, see Annex 4)

B. DETAILED PROJECT DESCRIPTION

1. Goals and Purposes

In accordance with the policies of both the GOI and the United States Government, the Project will seek to accomplish the following goals in the Project districts:

Goals

1. A significant decline in the Crude Birth Rate
2. A decline of 15% in the Infant Mortality Rate
3. A decline of 20% in the age 1-4 Mortality Rate

To accomplish these goals, following the model health plan of the GOI, the Project will have the following purposes:

Purposes

1. To improve access to health and family planning services that promote fertility and mortality reduction.
2. To improve and expand the services and support systems of the model plan.

2. Purpose 1: Improved Access

Access may be defined as the ability of persons to seek and receive services. Access is influenced by the distance to care, social factors, and costs of care. The fully implemented model plan will increase access by having two trained voluntary village-level workers for each population unit of 1000 people; more than doubling the number of subcenter units and personnel; adding one LHV for each four subcenters; and adding PHC's rural family welfare centers, and upgraded PHC's to planned levels.

Village-level workers improve access by decreasing the distance to care, reducing social barriers to care as they are themselves residents of the village, and by providing low cost services. Increasing the number of subcenters, subcenter personnel, and LHV's improves access by decreasing the distance to care; reducing social barriers by having adequate numbers of staff living close enough to the village to develop social rapport with the community; and by offering free care. Increasing the PHC's, rural family welfare centers, and upgraded PHC's improves access by decreasing the distance to special, higher quality services at no cost to the person except transport.

This Project will assist in reaching the model plan targets in five years in the selected districts rather than the ten years allowed for districts without external donor assistance. Assistance will include support for the training of additional workers, construction of additional service facilities and quarters, and salary support for additional person-years of work. Training and salary support is included due to the accelerated number of workers in the project-assisted districts compared with other districts. Construction of additional service facilities and quarters is included because the village-level workers, although exceedingly important for enabling rural people to enter the scientific health and family planning system, are not able to offer definitive care for most important problems contributing heavily to fertility and mortality. Such

problems require an organized, regionalized, hierarchical system of services as envisaged in the model plan in which the subcenter workers offer more and higher quality services than the village-level workers; the PHC's, rural family welfare centers (RFWCs), and upgraded PHC's offer more and higher quality services than the subcenter; and referral linkages between all levels of care are in existance and are functional. Construction of workspace with privacy, adequate lighting and adequate ventilation is necessary. In addition, construction of living quarters is included for females as it is difficult to recruit and retain female workers in rural villages without private and secure living quarters. If female workers are not present, access is severely hampered for fertility and mortality reduction services.

For the fertility and mortality reduction goals to be met, the entire system should be "operational". "Operational" means that all levels of the system are functioning--that is, offering services in a planned way--and people in need are using the services. For services to be given, workers must be in place and have supplies and equipment. Even if the system is "operational", the goals won't be met unless people in need, especially younger couples, pregnant women, infants, and young children from poor families, are using the system on a regular basis.

OBJECTIVELY VERIFIABLE INDICATORS FOR IMPROVED ACCESS IN PROJECT-ASSISTED DISTRICTS		
1. Trained CHV and Dai/mid-1982 rural population (1/1000 in the state of Punjab)	=	2/1000 people
2. Trained FMW/mid-1982 rural population	=	1/5000 people (1/3000 in Hilly and Tribal Areas)
3. Trained MMW/mid-1982 rural population	=	1/5000 people (1/3000 in Hilly and Tribal Areas)
4. % village of 1000 or more people having at least one trained village level worker	=	80%
5. % villages of 1000 or more people having one or more subcenter workers within a 30 minute walking time of village center	=	70%
6. % increase in persons using the CHV, trained dail or government health system	=	to be determined after baseline survey
7. % increase in persons needing care who receive it through the CHV, trained dai, or government health system.	=	to be determined after baseline survey

3. Purpose 2 : Improved & Expanded Services & Support System

The model plan has begun to be implemented throughout the country. The plan is expected to continuously improve and expand its services and support system during the coming years. The following sections describe how the services and support systems will be improved and expanded in the project-assisted districts and in training and management units that support the project-assisted districts. These sections are abstracted from the plans submitted by the states as part of the project planning process, and from preliminary analyses by USAID. Wherever possible, the format followed is that used by the states.

a) Subpurpose 2.1 : Improved and Expanded Services

The great majority of services important for fertility and mortality reduction are being offered under the existing service packages of the model plan. (for details, see Part III:A)

The states and the GOI have indicated a strong desire to improve the quality of existing services through regular "refresher" in-service training of existing workers in project-assisted districts. In addition, selected new services may be introduced after field testing and/or "refresher" training if a clear need is apparent after an assessment of disease patterns and if the services can be safely rendered. During the baseline needs assessment, the quality of existing services important for fertility and mortality reduction will be determined and plans made to improve services delivered below acceptable levels of quality. Some areas suggested for qualitative and quantitative improvement by previous evaluations and field visits include the following: motivation about child spacing; nutritional and high risk assessment in pregnancy; identification of and care for the low birth weight child; nutrition education for pregnant women and mothers of young children; and diarrhea care in young children.

	OBJECTIVELY VERIFIABLE INDICATORS FOR IMPROVED AND EXPANDED SERVICES
1.	80% of service workers give 80% of important fertility and mortality reduction services at acceptable levels of quality.
2.	Selected new services are introduced after field testing and/ or refresher training if a clear need is apparent and if the services can be safely rendered.

b) Subpurpose 2.2 : Improved and Expanded Support Systems

(1) IMPROVED AND EXPANDED TRAINING SUPPORT

The states recognize that they need an increased training capacity to fully implement the model plan in the selected districts in the five year period, to continue the regular progrms in the non-project districts of the states, and to begin yearly refresher training on a regular basis.

Besides the quantity issue, the states are also concerned about the quality of their training programs--basic courses, preservice programs, and inservice training. In their state plans, they have identified certain special areas of high priority for improvement including community health, Maternal and Child Health (MCH) services, management, and promotion of community involvement. Some states are concerned about how well the training curricula for workers are matched with the jobs of their field workers and all would like to strengthen the training capacity of their training institutions and the capabilities of their training staffs.

To expand and improve the capacity of the training institutions and the PHC's where training occurs, increased training space will be created. This increased space will allow more training "in the field" for female workers by construction of hostels for females at selected PHC's designated as field practice areas. In addition, increased training space will be provided at other PHC's to improve learning environments. This space (called training annexes by the GOI) will be used for basic training of multipurpose workers and village-level workers and for inservice "refresher" training of all categories of workers at the PHC, subcenter, and village as needed. The space will also be used for conducting community information, education, and communications meetings.

The states and the GOI have indicated a strong desire to improve the clinical, interpersonal, and management skills of existing workers through "refresher" training. During the baseline needs assessment, training needs for service workers and managers will be determined from which a training plan will be developed for refresher training. Priority skill areas suggested by the states for assessment include maternal and child health, planning, operations management including logistics management, monitoring, and evaluation. Special attention will be given to training in communications management at the district-level. Innovative training approaches may be tried.

The states and the GOI have also indicated a strong desire to improve the skills of trainers. The needs assessment will include an assessment of the skills of trainers in such areas as job analysis, curriculum development, active learning techniques, development of educational materials, student evaluation, and post-training evaluation. The states have suggested that the trainers may also need improvement in maternal and child health, community health, community involvement techniques, and especially in communications training.

	OBJECTIVELY VERIFIABLE INDICATORS FOR IMPROVED AND EXPANDED TRAINING SUPPORT
1.	An increased proportion of basic training courses training time is "in the field" at PHC's with improved training capacity.
2.	80% of existing service workers, managers, and trainers receive inservice "refresher" training atleast three times during the project.
3.	80% of managers and trainers have important skills at acceptable levels of quality.

(2) IMPROVED AND EXPANDED COMMUNICATIONS

The GOI and the states place high priority on the improvement and expansion of their communications capability with particular emphasis on informing the public about the benefits of family planning and improved health habits, the services available at government units, and where government health and family planning services are located. Five main areas for improvement and/or expansion have been identified and detailed plans will be made after a communication needs assessment.

Firstly, the GOI plans to improve the communications knowledge and skills of service workers particularly in the area of interpersonal communications. To accomplish this, training programs and materials will be developed for inclusion in yearly refresher training of existing workers and in basic training courses. Emphasis will be given on why it is important to understand the views of the villagers in trying to achieve behavioral change. An important aspect will be the development of training content and training materials specific for each of the individual districts so that the material is culturally relevant.

Secondly, to promote community involvement, particularly in the family planning program, existing orientation training camps for village leaders will be intensified so that, in every village, these community leaders communicate positive beliefs about the small family norm and about the benefits of child spacing. District level training with localized training content should maximize the effectiveness of this training. Educational camps will also be organized for block and district leaders.

Thirdly, to improve cooperation and coordination with other departments of the government, field workers from other departments will be trained in family planning motivation and education using district specific training content and materials. Particular efforts will be made to incorporate these materials into the National Adult Education Program in project-assisted districts.

Fourthly, to improve the management of communications efforts through decentralization of responsibility to the district level and improved skills in communications management, district and block extension educators will be trained in planning, operations management, and evaluation. If necessary, the staffs of the district office will be increased.

Fifthly, to improve the communications training capability at the district and block levels, the staffs will be increased and their training skills improved.

OBJECTIVELY VERIFIABLE INDICATORS FOR IMPROVED AND EXPANDED COMMUNICATIONS
1. 80% of existing service workers have improved skills in interpersonal communications.
2. Locale-specific communications materials are produced at the district level on a regular and on-going basis.
3. 80% of villages have had at least two leaders trained in orientation camps.
4. 25% of field workers from the government departments have been exposed to inter personal approaches to family planning and health motivation.
5. 80% of district and block level extension educators and other staff with communications management responsibility have improved communications planning, operations management, and evaluation skills.
6. 80% of district level staff having responsibility for communications training have improved skills in communications training and in development of locale-specific training materials.

(3) IMPROVED AND EXPANDED EXISTING SERVICE FACILITIES

While additional facilities are to be constructed to improve access, selected existing facilities are to be improved and expanded to improve the quality of services. PHC units are to be improved and expanded to offer better quality surgical and emergency care services (operating theater) and improved child care (space for beds). Upgraded PHC units and subdistrict hospitals are being improved and expanded to offer better quality surgical, obstetric and emergency care services (operating theater) and improved acute and special care for children (space for beds).

To meet fertility and mortality reduction goals, these facilities must be "operational"- that is, have workers in place with adequate supplies and equipment - and must be serving people in need, especially younger age couples, pregnant women, infants, and young children from poor families on a regular basis.

OBJECTIVELY VERIFIABLE INDICATOR FOR IMPROVED AND EXPANDED EXISTING SERVICE FACILITIES
1. 100% of improved and expanded facilities of each type are operational by the end-of-project.

(4) IMPROVED AND EXPANDED MANAGEMENT SUPPORT

The states have indicated great interest in strengthening their management capabilities both within the districts and between the districts and other level units. They are particularly interested in the improved monitoring of service and support system activities; in improving program operations through altering management procedures and patterns and by conducting practical research studies; and in evaluation of the impact of their programs.

Monitoring will be improved by the development of a management information system that will assess both services and support systems performance. For services, outputs by type of service, age, sex and income distribution of users will allow program managers to decide if people in need, particularly women and children from poor families, are using the government health system. For planned programs with targeted objectives, progress toward the targets can be monitored. For support systems, the management information system will give priority to improvement in logistics management at the periphery (ordering, inventory control, assuring that critical drugs, equipment, and supplies are usually available. In addition, the system should assist in personnel management (vacant posts, transfers); in quality control (improved supervision and reporting); and in planning (workload analysis, investigating why deficiencies occurred). The data should be collected and analyzed on a short interval, periodic basis so that program managers have timely information that can help change the program if necessary. An important part of the program will be to reduce the data collected to a form that is necessary for decision-making and improve the data analysis at the block, district, and state levels.

Program operations will be improved by altering management procedures and patterns where appropriate as a result of the baseline needs assessments and improved monitoring system which will have indicated the problem areas. In addition, practical research studies will be done to improve program operations. These studies will arise from perceived needs of decision makers, during or by the results of the baseline needs assessment phase, and from implementation itself. The states have suggested that these studies include the following broad categories: studies used as baseline data for planning: studies related to project implementation strategies; studies in the field of management and training; studies related to service delivery; and studies related to communication, education, and community involvement. Special attention will be given to groups with low utilization and to strengthen the prediction of contraceptive demand.

Impact evaluation capability will be improved by increased staffing of the Evaluation Cells at both state and district levels, by training of the Evaluation Cell personnel, and by involving the Evaluation Cell in the baseline and follow-up surveys and in analytical studies.

OBJECTIVELY VERIFIABLE INDICATORS FOR EXPANDED AND IMPROVED MANAGEMENT SUPPORT
1. An improved management information system is in use in project-assisted districts and between project-assisted districts and higher level management units.
2. All states have carried out at least one practical research study in each of the following areas: baseline data for planning; project implementation strategies; management; training; service delivery; and communications, education, and community involvement.
3. Skill levels of Evaluation Cell workers are improved at both the district and state levels in comparison with findings during the baseline analytical surveys.

4. Outputs of the project

Seven general categories of outputs are listed on the following pages with their specific output and the quantity target for the project. Three categories relate to purpose 1: improved access, and four categories relate to purpose 2: improved and expanded services and support systems. It can be seen that in some categories of purpose 2, the outputs are not yet specified as these outputs can only be determined after the baseline needs assessment is completed. At that time, a second planning round will occur and other project outputs will be specified.

OUTPUTS FOR PURPOSE 1 - IMPROVED ACCESS

Category of Output	Specific Output	Quantity of Output
Additional Trained Workers	Additional CHV's trained	5681
	Additional Dai's trained	9963
	Additional FMW's trained	2308
	Additional MMW's trained	432
	Additional LHV's trained	399
Additional Service Facilities and Quarters Constructed	Additional Subcenters Constructed	1389
	Additional PHC's constructed	8
	Additional Rural Family Welfare Centers constructed	101
	Additional upgraded PHC's constructed	34
	Additional LHV quarters constructed	650
Additional person-years of work	Additional person-years of work by CHV's	About 22200
	Additional person-years of work by trained dais	About 36800
	Additional person-years of work by FMW's	About 6400
	Additional person-years of work by trained MMW's	About 1300
	Additional person-years of work by LHV's	About 1300
	Additional person-years of work by medical officers at PHC's	About 200
	Additional person-years of work by medical officers at upgraded PHC's	About 280
	Additional person-years of work by nurses at upgraded PHC's	About 180

OUTPUTS FOR PURPOSE 2.1 - IMPROVED & EXPANDED SERVICES

Category of Output	Specific Output	Quantity of Output
Improved and Expanded Services	Analysis of family planning and disease patterns in districts	1
	Analysis of service quality in project-assisted districts	1
	Existing CHV's with improved skills	5882
	Existing dais with improved skills	5497
	Existing FMW's with improved skills	1183
	Existing MMW's with improved skills	1982
	Existing LHV's with improved skills	229
	Existing Health Assistants with improved skills	693
	Existing medical officers with improved skills	267
	Innovative services field-tested	To be determined after baseline service needs and disease assesement.

OUTPUTS FOR PURPOSE 2.2 - IMPROVED & EXPANDED SUPPORT SYSTEM

Category of Output	Specific Output	Quantity of Output
Improved and Expanded Training Support	Training needs assessment for service workers, managers, trainers, and training institutions serving project assisted districts	1
	Additional training facilities constructed	47 *
	Additional managers trained) Existing managers with improved skills)	To be determined after training needs assessment
	Additional trainers trained) Existing trainers with improved skills) Additional person-years of training by trainers)	To be determined after training needs assessment
	Innovative training activities field tested	
Improved and Expanded Communications Support	Thorough communications needs assessment	1
	Community people trained through training camps) District and block level people trained through camps)	To be determined after communications needs assessment
	Field workers from other government departments) trained in family planning and health communications) Communications managers trained) Communications trainers trained)	To be determined after communications needs assement
	Innovative communications activities field tested	To be determined after communications needs assessment

* consists of 16 FMW (ANM) training annexes at PHC's, 29 training/community meeting rooms at upgraded PHC's, 1 MMW training center, 1 Regional Family Planning Training Center.

OUTPUTS FOR PURPOSE 2.2 (continued)

Category of Output	Specific Output	Quantity of Output
Improved and Expanded Existing Service Facilities	Existing PHC's renovated	37
	Existing PHC's with an operating theater added	67
	Existing RWFC's renovated	3
	Existing subdistrict hospitals renovated	2
Improved and Expanded Management Support	Management information system developed for monitoring of services and support systems	5
	Practical research studies completed	30 (minimum of five per state).
	Baseline surveys, mid-term evaluation, and end-of-project evaluation	1 each

5. Inputs

The project inputs are financial, technical, and managerial. The technical inputs include the knowledge of the public health/family planning specialists, trainers, communications specialists, engineers, and survey/evaluation specialists who work in the project. The managerial inputs include the knowledge of the project planners and managers involved in the project. These people assist in the transformation of untrained people to trained ones, of raw materials into buildings, of lesser developed management and communications systems into improved ones, and so forth. The project plan is to use the excellent capability of Indian professionals and institutions to provide the technical and managerial inputs while the GOI, the states, and USAID will provide the financial inputs. The total project cost is $64.75 million and the USAID contribution is $40 million to be disbursed within five years. All goods and services under this Project are expected to be procured locally.

PART III : PROJECT ANALYSIS

A. SERVICES

1. Fertility Reduction Services

The Model Plan offers a variety of family planning services to the population. Although, in the past, the family planning services have emphasized sterilization, the government now is also emphasizing child spacing services to promote health and a smaller family norm. Community participation also plays a key part of the program.

Family planning services at the village level include family planning motivation, condom distribution, and referral. Motivation emphasis is on the benefits of child spacing and delayed age of first pregnancy for young women and on spacing and sterilization for older men and women having two or more living children with the youngest aged two years. At the subcenter, services include motivation and counselling, IUD insertion, oral pill distribution (with follow-up within three months by a physician), condom distribution, distribution of conventional contraceptives (diaphragms, jellies), and referral for sterilization. At the PHC, in addition to all services available at the subcenter, female and male sterilization services are available.

Recent assessments of the Model Plan approach indicate that appropriate services are becoming available through the plan but that improvements in knowledge of all contraceptive methods and improvements in interpersonal motivation and counselling skills are needed at all levels. In addition, village and subcenter personnel sometimes lack supplies. These weaknesses will receive priority attention during the needs assessment and throughout project implementation. Fortunately, Gujarat and Majarashtra have the best record in family planning in India and the other states are also progressive and highly motivated.

The family planning package of services is technically sound and, with planned improvements in worker skills and contraceptive supply systems, should achieve the goals of the Project in the time specified. Greater details can be found in Annex 1.

2. Mortality Reduction Services

The Model Plan offers a variety of basic health services to the population. As such, mortality reduction services for children 0-4 years are only a part of the responsibilities of the workers. Since village workers are "primary health care" workers, the community plays a major role in their day-to-day work. Subcenter workers, on the other hand, are government employees and work as part of a planned effort as well as meeting the demands of the population they serve.

Mortality reduction services at the village level include treatment of minor ailments; recognition and presumptive treatment for malaria; recognition and emergency treatment for acute diarrhea in young children; recognition and referral for serious cases including young child mal-

nutrition; pregnancy care with special emphasis on care for the normal, uncomplicated delivery; and family planning, health, and nutrition education. The subcenter offers more and higher quality services and has planned community intervention programs. Services include immunizations, good quality antenatal care including high risk assessment, malaria detection and treatment, tuberculosis detection and treatment, well chlorination, and family planning, health, nutrition, and sanitation advice.

The PHC units offer a wide range of health services including selected emergency surgical and obstetrical services, infectious disease treatment, and limited in-door (in-patients) care.

Since the Model Plan has broad responsibilities, there are areas where mortality reduction services are less prominent. At the village level, improved services to recognize severe infections, low birth weight, and malnutrition would improve the mortality reduction potential. At the subcenter, the addition of emergency treatment for pneumonia, septicemia, and meningitis would decrease mortality in infants and young children. At the PHC, improved care for low birth weight babies and women with difficult pregnancies would improve the mortality picture. During the baseline survey, disease patterns will be assessed to determine if any additional services need to be field tested to enhance mortality reduction potential.

Thus, the basic health services offered through the Model Plan are technically sound and, with improvement in selected areas, should assist in achieving mortality reduction for infants and young children.

3. Effectiveness of the Model Plan for Fertility and Mortality Reduction

After the first AID/W review in July of 1979, an AID team visited India specifically to address the question of whether India's rural health delivery scheme is providing health and family planning services at the village level (see Annex 1). Besides this question, the report devoted considerable effort to an analysis of subcenter effectiveness. The conclusions of that report, paraphrased from page 18, are as follows: (1) the scheme is fundamentally sound overall, (2) it does need improvement in selected areas, (3) the central and state governments are aware of and interested in improvements, and (4) the project - if designed to improve planning, evaluation, and training, through activities such as baseline surveys, establishment of a management information system, operations research to develop effective ways of training workers and delivering services, and demonstration projects to test innotavtions - should strengthen the basic health and family planning system sufficiently to achieve the project's goal of reducing fertility, mortality, and morbidity. AID/W endorsed this report in October 1979.

The effectiveness of the scheme is also related to the human resources that will be applied to the project areas. For the first time, the government will have an adequate number of subcenter workers close to the village so that a sustained presence and effect should occur. These workers are extended by village-level workers who are excellent motivators and educators and can recognize seriously sick from non-seriously sick patients.

If the subcenter workers maintain their community orientation, have their services extended by trained village workers, have support by a FWS system with effective family planning and health services referral follow-up, and can perform important tasks effectively, significant reductions in fertility and mortality should occur.

4. Progress to Date in Implementation of the Model Plan

The Model Plan is at various stages of implementation in the Project states. Gujarat is furthest along in implementation having trained 75% of CHV's, 50% of dais, and virtually all MMW's. Gujarat will need additional FMW's as the subcenter system expands.

Maharashtra has made very fast progress in converting male unipurpose workers to MMW's, but proceeded cautiously in implementing the CHV's and dais at first, having decided to gain field experience with these workers by fully implementing the program in 2-3 blocks per district. Now, however, they are moving rapidly to implement the village-level programs throughout the state and expect to fully implement the Model Plan by the target date.

Haryana is also fairly well along in implementation, having trained about 50% of CHV's, 70% of dais, and most MMW's. They also will need more FMW's.

Punjab has modified the Model Plan to suit their plans and needs. They have trained about 70% of the planned number of dais, but are not implementing the CHV program. Instead, they will strengthen the sub-center by adding a physician and a lab technician in addition to the MMW and FMW. About 80% of the physicians are already in place. The project will support the dai training, MMW training, and FMW training parts of the program in the Punjab.

Himachal Pradesh has already trained 80% of CHV's but has made least progress so far in dai and FMW training. Only about 10% of the dais and 25% of the FMWs have been trained so far. However, interest in Himachal Pradesh is high and they are attempting to overcome difficult terrain problems and a relatively less developed population and infrastructure.

B. SUPPORT SYSTEMS

1. Training

The system for offering basic training to rural health and family planning workers is well established and experienced trainers exist in all of the five states. For the basic training of village-level workers, the GOI has adopted a decentralized approach and the CHV's are trained by the PHC doctor while dais are trained by the FMW's and LHV's. The retraining of the MMW's is also decentralized to the PHC. The advantages of decentralization are rapid implementation and training on common problems of the districts. The disadvantages are in quality control and recent evaluations have pointed out

that the trainers themselves often lack training skills and training materials and students learn through memorization rather than through supervised work experience in the actual work setting. The result, as shown in the evaluations, is that the village workers have variable knowledge depending on their trainer and are often unable to perform basic tasks such as measuring out the correct amount of oral rehydration salts.

The basic training of FMW (ANM) is at FMW's training schools. Their present training experience has been hampered by lack of experience in the field and by spending too much time in hospital settings. FMW's suffer from a heavy emphasis on the lecture technique and lack of practical "hands-on" training.

Regular in-service training is not yet well established for existing workers. The PHC doctor has the responsibility of organising this "refresher" training but lacks guidance, skills, training materials, and time.

Overall, however, vast numbers of workers are being trained and the training support system is steadily improving. The GOI and the states recognize where training should be improved and this Project will specifically address the problems existing now.

2. Communications

In the past, the main communications strategy has been to create awareness about family planning through mass media approaches such as the "Red Triangle" and the "Four Faces" campaigns. This approach was very successful in creating awareness of family planning throughout the country. Now, however, it is necessary to translate awareness into acceptance and new approaches have been planned which stress extension services and improved interpersonnel communications.

At the village-level, village workers will be trained in interpersonal communications and village leaders will be trained in training camps. Locale-specific materials will be developed and other government workers will also be trained. Population education will be introduced into the schools and into Adult Education Programs. Subcenter workers will also be retrained in interpersonal approaches. Existing communications set up at the block and district levels will be strengthened.

The new GOI strategy is technically and socially sound and the Project will play an important role in implementing the new strategy in the selected districts.

3. Management Support

The states and districts have extensive management responsibilities including planning, service program management, personnel management, logistics management, financial management, research and development, evaluation, and public relations. Planning capability is relatively good although some improvements in planning by objectives could be made.

Service program management has been strengthened by the addition of one LHV supervisor for every four subcenters and will be further strengthened by the development of an information system which can monitor overall quality of services.

Personnel management has been a problem in some states in the past and vacant posts, frequent transfers, and absentism are much more common in rural service units than urban ones. The Project should improve this situation by building adequate quarters for females, by having more frequent supervision, and by regular retraining programs for the workers. Other innovative approaches to improve worker satisfaction may be developed as part of the Project. The GOI has stated that vacant posts in Project-assisted districts will be filled on a priority basis.

The logistics system will be investigated as part of the baseline needs assessment. In the past, there have been supply problems particularly at the remote units. At the present time, neither the GOI nor USAID can accurately say which specific contraceptive supplies and equipment are in short supply or out of stock relative to current or projected demand in different districts or groups. Some logistics problems are financial, but others might be improved by better logistics management. If child spacing services are to be effective, contraceptive availability must be assured through appropriate ordering, inventory control (buffer stock), and distribution practices consistant with expected demand.

The states and districts are keenly interested in improving their research and development and evaluation capability as described in the project design. The experiences gained throughout the Project should greatly strengthen this capacity.

The staffing levels in the states and districts for management personnel are minimal at present. This Project will add ample staff for management of the project itself (see administrative arrangements section) and the management needs assessment may suggest other areas for expanded management staff.

C. CONSTRUCTION

1. General Design and Specifications

The design plans will follow standard plans developed by the GOI. The Public Works Department's (PWD's) of each state will modify the designs to meet local conditions. Materials specifications are standard and used in building construction all over India. Local materials are used. Site selection criteria have been developed and include ready access to the site by the population and close proximity to other public services, utilities, and roads when possible. Sites for major buildings will have electricity and a potable water supply.

2. Construction Management

Bidding and construction procedures will follow the standard practices of the state PWD's. Bids are publically invited through advertisements and by notifying contractors registered by the state. Bids are based on established PWD schedules plus a premium included by the bidders. The lowest responsive bidder is awarded the contract. If all bids are high, the states reserve the right to repeat the bidding process. If not acceptable bids are received, the work is carried out by force account or on a piecework basis. Contractors use local labor to carry of the work. Supervision is carried out by the PWD department using inspectors and junior engineers.

Each state PWD is responsible for preparing cost estimates for all the building activities of the various departments of the state and has prepared a rough cost estimate for the buildings under the proposed project based on agreed upon design criteria. Cost estimates include an annual allowance of 10% for added labor and materials costs due to escalation in prices during the construction period of about four years. (For detailed engineering analysis, see Annex 5).

Construction of the subcenter units may not be a high priority for bidders as the units are small and in remote areas. To enhance the timely completion of these units, special construction cells will be established in each state to plan, manage, and evaluate the construction component of the Project (see administrative arrangements section).

During Project development, maintenance was discussed with GOI and state officials. While maintenance has been a problem for all government buildings, assurances have been given that buildings will be maintained adequately.

The construction plans are technically, financially, and administratively sound. On the basis of the above analysis, the requirements of Foreign Assistance Act Section 611(a) have been met.

D. FINANCIAL ANALYSIS AND PLANS

1. Project Costs

The total cost of the project is $64.75 million to be disbursed within a five year period. Forty million dollars will be a grant from the United States Government and $24.75 million will be contributed by the Government of India and the respective state governments. In addition to the Project costs, the districts involved are expending about $9.39 million in FY 80. Assuming a 5% increase in expenditures per year, the districts will expend about $54.47 in addition over the five year life of the Project giving an estimate of total expenditures at about $119.22 million in Project-assisted districts. Under these conditions, the USAID contribution is about 33% while the GOI and states contribute about 67%. During that same period, the GOI is estimated to be spending over $1740 million in health and family planning activities countrywide so that the USAID contribution is about 2.3% of all public sector expenditures for health and family planning.

2. Financial Analysis

a) Expenditures by purpose indicator

The expenditures by purpose indicator and output category are shown below. The first purpose, improving access to services by assisting in a

more rapid implementation of the model plan, will use 77% of the total project expenditures while the second purpose, to improve and expand the Model Plan services and support systems, will use 23% of the expenditures.

SUMMARY OF FINANCIAL INPUTS BY OUTPUT CATEGORY

PURPOSE	CATEGORY OF OUTPUT	RUPEE COST (000)	$COST(8:1) (000)	% BY OUTPUT CATEGORY	% BY PURPOSE
1	Additional Trained Workers	22,958	2,870	4%	
Improved Access	Additional Service Facilities and Quarters Constructed	232,715	29,089	45%	77%
	Additional Person-years of Work	143,035	17,879	28%	
2	Improved and Expanded Services	9,304	1,163	2%	
	Improved and Expanded Training and Manpower Development	15,186	1,898	3%	
Improved and Expanded Services and Support System	Improved and Expanded Communications	16,454	2,057	3%	23%
	Existing Facilites Renovated	32,617	4,077	6%	
	Improved and Expanded Monitoring, Research, and Evaluation Capability	45,688	5,712	9%	
	T O T A L	517,957	64,745	100%	100%

b) Expenditure By Project Activity and Source of Funds

The table below shows expenditures by Project activity and source of funds. For example, construction and initial equipment costs are 53% of the Project total and AID will pay 61% of the total construction costs. Salary support is 23% of the total project costs and AID will pay 50% of the total salary costs. The basic rationale for the AID contribution is that AID will pay 50% of the costs of salaries and drugs as the Model Plan is being implemented at twice the rate in project-assisted districts. In this situation, the costs to the states will be expanding at the normal

10 year implementation rate for the model plan during the life of the Project. AID will pay for nearly all of the one-time only developmental costs and will pay for 61% for construction. For training, AID will pay the entire costs during the Project lifetime. AID's overall contribution is 62% of the Project costs. The GOI undertakes to insure internal resources for financing the remaining Project costs.

FINANCIAL INPUTS BY ACTIVITY, SOURCE OF FUNDS AND USAID CONTRIBUTION
($ in 000's)

A C T I V I T Y	GOI/ STATES	USAID	TOTAL	% OF TOTAL PROJECT	% CONTRI-BUTION BY AID/ACTIVITY
Construction and initial equipment	13,394	21,233	34,627	53%	61%
Salary Support	7,562	7,563	15,125	23%	50%
Training	-0-	3,783	3,783	6%	100%
Communications	-0-	973	973	2%	100%
Drugs	2,160	2,160	4,320	6%	50%
Research/Innovative/ Contingencies	-0-	2,438	2,438	4%	100%
Transport	1,629	-0-	1,629	3%	0%
Management Information Systems Development	-0-	1,050	1,050	2%	100%
Monitoring and Evaluation	-0-	581	581	1%	100%
Project Management	-0-	219	219	-	100%
T O T A L	24,745	40,000	64,745	100%	62%

c) Expenditures by State and Person

The table below shows the project expenditures by state and person in the project-assisted districts. Expenditures by state by year are shown in Annex 7.

S T A T E	PROJECT EXPENDITURE ($000's)	ESTIMATED POP. IN PROJECT DISTRICTS (Rural - in 000's)	PER CAPITA EXPENDITURES IN DISTRICTS
Himachal Pradesh	13,755	1,500	$9.05
Punjab	9,872	3,400	2.90
Haryana	9,673	1,900	5.09
Gujarat	14,817	3,100	4.78
Maharashtra	16,628	3,600	4.62
T o t a l	64,745	13,500	$4.80

d) Expenditures by Project Year (in $000's)

Source	Year 1	Year 2	Year 3	Year 4	Year 5	Total
GOI/States	5,370	5,848	5,806	3,984	3,737	24,745
AID	8,681	9,454	9,385	6,439	6,041	40,000
Other	-	-	-	-	-	-
Total	14,051	15,302	15,191	10,42[illegible]	9,778	64,745

e) Recurrent Costs

Average recurrent health service costs as of 1980-81 are approximately $800,000 per district in the five project states, or about $62 million for the entire 78 districts. The effect of implementation of the Model Plan will be to increase average recurrent costs by about 33% per year in the Project districts, and by perhaps 17% initially in the 65 non-project districts (where the Model Plan will be implemented over 10 years rather than five years). For the period 1980-81 to 1984-85, the proposed AID grant will cover roughly half the increase in recurrent costs in the project districts. Consequently, the average increase for both project and non-project districts for the five years of the project will be on the order of 17%. During the subsequent five years the average recurrent cost increase will gradually rise to 33% per district as the Model Plan reaches full implementation in all 78 districts. Under existing cost-sharing formulas, nearly three-fourths of these recurrent costs will be covered by the central government. Inasmuch as recurrent costs for health and family planning account for only about 5% of total GOI recurrent expenditures, the GOI should have no difficulty in providing the necessary financing (particularly given the very high priority which the GOI accords to rapid expansion of basic health services).

E. ECONOMIC ANALYSIS

The goals of this project are fertility reduction and mortality reduction. Fertility reduction may be regarded as a way of reducing the "demographic investment" of a society. This is the investment which must be devoted to maintaining a constant level or per capita income and services as population increases. In addition, high dependency burdens on families reduce the savings capacity of a society. Also, high fertility among the poor contributes to an excess supply of unskilled labor and a downward pressure on wages; this has unfavorable effects on income distribution. Because estimation of these economic consequences of fertility reduction would require a relatively sophisticated simulation modelling effort, no attempt has been made to quantify the likely economic benefits although the effect of fertility reduction should increase both savings and investments.

Mortality reduction may be both an end in itself and a means to the achievement of other social and economic objectives. As an end in itself, it should be regarded as a consumption good. In this case, resource allocations promoting health are justifiable as a contribution to the enhancement of the quality of life for the beneficiaries. When reduced mortality is seen as a means to the achievement of other social and economic objectives, resources allocation can be regarded as an investment with an expected return on that investment. The policies of the GOI and AID to meet basic human needs through equitable growth recognize both the consumption and investment aspects of mortality reduction.

Investments in general health services may be assessed in terms of two possible classes of benefits: increases in production either from increases in labor availability and productivity or improvements in population quality and "human capital". This latter class of benefit derives from changes in attitudes toward education and skill development which result from longer life expectancies. This project, although focusing on mortality reduction in children under age five, will contribute to overall mortality reduction as well. Benefits in these two classes are extremely difficult to estimate, but may be substantial even in situations of overall labor surplus. According to research carried out by Ram and Schultz using Indian data, for example, a 1% fall in mortality may be associated with a 0.3% increase in agricultural output (see Ram, R. and Schultz, T., "Life Span, Health, Savings, and Productivity". Economic Development and Cultural Change, April 1979). Because of the complexities involved, a benefit cost analysis of the impact of mortality reduction has not been prepared.

Cost-effectiveness analysis is probably more relevant than benefit - cost analysis for projects of this type. Although USAID has not carried out such an analysis in planning this project, it is important to recognize that the Model Plan represents the result of 15 years of program development based on implicit cost-effectiveness criteria. The outcome is an approach to rural health and family planning which uses village-level workers, mid-level workers, and physicians as teams to maximize access to services and has simple services rendered by least trained

people and complex services rendered by more highly trained people. Evidence of the success of these efforts is that the Model Plan (if successfully implemented) will quadruple coverage of the health services from 20% to 80% of the population, with an increase of only 33% in recurrent costs. This implies that real recurrent costs per person reached (per capita health costs) will decline to one-third of their present levels by year 10. An important component of this reduction is based on expected gains in both effectiveness and efficiency deriv ing from an integrated approach to the administration of health and family planning services.

On the basis of these considerations, USAID believes that the project is economically sound as an investment in economic development and is a cost-effective means of meeting basic needs. USAID will encourage the incorporation of explict cost-effectiveness analysis into project evaluation and into the innovative field experiments to be carried out during the project life of the project.

F. SOCIAL SOUNDNESS

As the United States Congressional mandate to AID is to focus U.S. assistance on the poor, the districts chosen are economically disadvantage and the people, in general, have high fertility and poor health status. Within these districts, however, income is not distributed entirely equally and an important social soundness issue is whether poor families, particularly poor women and children, will utilize the trained village-level workers and the government's rural health system frequently enough, and for the "right" problems, so that fertility and mortality is reduced.

In the past, the government health system has not really reached into the village but has operated in larger population groups. The government workers were seldom local residents and often did not empathize with rural people. As a result, there were frequent transfers and many posts remained vacant at the periphery. In addition, PHC's were often short of essential drugs, waiting lines were long, contact time with the physician was very short, and the system only operated 4-6 hours a day. As a result, the rural people often used the private and traditional practitioners for a majority of their health and family planning problems. Private and traditional practitioners were well liked because, being dependent on the goodwill of their clients, they were almost always available, spent ample time with each client, dispensed treatments immediately from their own stock in most cases, treated their clients with respect, and were usually fellow villagers or at least permanent residents of the area. Unfortunately, traditional practitioners lacked information and sometimes took advantage of their clients.

The GOI, recognizing the strengths and weaknesses of the private and traditional system, decided to train the dais in the late 1960's. In 1977, the GOI announced the model plan which has a firm commitment to training workers for village-level care through its Community Health

Volunteer program. The GOI also decided to markedly expand government subcenters to improve access by villagers, and unipurpose workers were retrained to offer multiple services. At the village level, the model plan depends on community participation to select the CHV and the CHV has been made dependent on the community rather than the government for his (her) success. Evaluations showed good utilization by poor people although, as the CHV was invariably a young male, poor men were major users of CHV services. The trained dail on the other hand, offers services almost exclusively to poor women and children. At the subcenter, the FHW has been given the job of training the dai which enhances her reputation in the community. In addition, she makes frequent home visits which allows her to know the villagers well. The GOI, having experienced the strong village support for the village and subcenter-level workers and having learned from 15 years of family planning motivational efforts, also has adopted a communication strategy to use the strengths of the model plan system. The new communications strategy is based on extension into the village, training in interpersonal communications skills, use of locale-specific motivational materials and training content, and decentralization of responsibility to the district level. This is a sound approach.

However, many social barriers remain which inhibit utilization of the CHV, trained dai, and government rural health system by poor women and children. The foremost barrier is the longstanding partial seclusion of women (most prominent in poor families) which makes it sifficult for them to seek health or family palnning advice away from their homes for themselves or their children. Another serious barrier is social attitudes which often affects the workers attitudes toward the people. A third is intra-village social group competition which may inhibit poor people from one social group from using a village worker belonging to another social group, and a fourth barrier is competition from the private and traditional practitioners whose income may be threatened. The key fact, however, is the positive trend. Social barriers for poor people, particularly women and children, are decreasing and the model plan approach is enhancing that process. The careful monitoring of utilization patterns by the management information system will allow Project managers to investigate situations where the poor are using the system at low rates to determine what changes are necessary to encourage better utilization. This information will enhance the social soundness of the model plan even more. The AID team which visited India in September of 1979 (see Annex 1) concluded the following in its social analysis section (see page 7): "it can be said that the delivery system of health care and family planning services as presently designed and in operation is consistent with prevailing norms and practices and that we see no serious obstacles to the ability of the proposed project to provide effective health care and family planning services in rural India."

PART IV : IMPLEMENTATION PLAN

A. ADMINISTRATIVE ARRANGEMENTS

1. GOI and State Administraiton of the Project

The project will primarily be managed by the state governments with overall supervision by the GOI and monitoring by USAID. For specialized technical assistance, Indian professionals and organizations will be employed by the states. As mentioned in the analysis section

of the paper, the staffing levels at the state and districts are minimal given their large job responsibilities. For this reason, special project offices will be established at the state and district levels. The project offices will be supervised by "project advisory committees" at all levels - district, state, and central. Organizational charts and detailed arrangements for each level are found in Annex 7. A summary is given below.

At the center, the Ministry of Health and Family Welfare (MOHFW) will be responsible for overall coordination of the Project and will insure that all terms of the Project Agreement are fully met. A senior officer of the rank of Joint Secretary will be the Central Coordinator. He/She will be assisted by the regular staff of the Ministry. A Central Project Advisory Committee, chaired by the Secretary or Additional Secretary-cum-Commissioner for Family Welfare will meet annually to review project progress and to render policy guidance. A USAID representative will be a member of that Committee and representatives from AID/Washington may be invited to attend its meetings.

At the state level, the state ministries of health and family welfare will be responsible for implementing the Project. Each state will appoint a Project Director, of the rank of Special or Joint Secretary, who will be responsible for all aspects of the Project. He/She will have a staff paid from Project funds, including a Planning and Implementation Cell, a Construction Cell, and a Research and Evaluation Cell. The states will have a Project Governing Board, chaired by the Chief Secretary of the state, that will meet quarterly to review the progress of the Project and to approve plans for the next quarter. USAID representatives will be invited to the meetings of the State Governing Boards.

Within the districts, the Chief District Medical Officer will be responsible for project implementation. He/She will have a staff paid from project funds including a Planning and Implementation Cell, a Construction Cell, a Research and Evaluation Cell, and a Communications Cell. The districts will have a District Project Advisory Board chaired by the District Collector (in charge of all developmental activities in a District). In consultation with MOHFW, USAID representatives will make periodic visits to the Project districts.

As some states have problems with vacant posts, the GOI and the states have agreed to fill vacancies in project-assisted districts on a priority basis during the first year of the Project and to maintain optimum staff levels during the rest of the Project period.

On this basis, the administrative arrangements of the GOI and states are sufficient to manage the project.

2. <u>USAID Administrative Arrangements</u>

a. Disbursements

The total cost of the Project is $64.75 million of which AID's contribution is a $40 million grant. As discussed in the financial analysis, AID will finance portions of Project activities eligible for reimbursement, including some expenditures from April 1, 1980 as specified in the Project Agreement and Implementation Letters.

b. Project Monitoring

For project monitoring, USAID will follow the administrative arrangements discussed previously. USAID's field monitoring functions will be coordinated with those of the states and COI where possible and will include periodic site visits to the districts by USAID staff by mutual consultation with MOHFW.

B. IMPLEMENTATION PLAN AND SCHEDULE

A bar chart by Project activity is found in Annex 9. A narrative follows.

By the end of the first Project year, the following tasks should have been accomplished: Project staff selected and oriented at the state and district levels; the baseline surveys and needs assessments have been carried out, the analysis done, and the reports submitted; critical drugs, supply and equipment levels have been determined and plans made to make critical items available on a priority basis; vacant posts have been filled in all project-assisted districts; construction cells have been established at state and district levels and construction starts have been made on 15% of subcenters, LHV quarters and FMW training annexes; contracts have been let for institutions that will train trainers, managers and communication staff and 75% of project management and project training staff have received at least one basic course in management or educational science; 15% of additional service workers have or are receiving basic training; and basic design of the management information system has occurred including pretesting of some records and reports.

By the end of the second Project year, the following tasks should have been accomplished: detailed action plans, based on the baseline surveys and needs assessments, have been prepared by all states; construction starts have been made on 50% of additional subcenters and LHV quarters, construction of all FMW training annexes have been completed and construction starts have been made on MMW and Regional Training Centers; 75% of managers and trainers have received advanced courses in their fields; 50% of additional service workers have received or are receiving basic training; 50% of existing workers have received at least one "refresher" course; drug supply, and equipment resupply system improvements have occurred for critical items so that they are usually present; long term field testing of management information system records is underway; and research and innovative activities have begun in all states.

By the end of the third Project year, the following tasks should have been accomplished: construction completion have been made of MMW and Regional Training Centers and 65% of subcenters and LHV quarters; construction starts have been made on all the remaining units proposed for construction; basic training of all village level workers and 65% of paramedical staff completed; 75% of managers and trainers have received "special skill" courses in their fields; 90% of existing workers have received at least one "refresher" course and 25% have received a second "refresher" course;

management information system has been fully developed and some subsystems are being implemented through training of workers and replacement of existing records and reports; the mid-Project evaluation has been held.

In the fourth year, the following will occur: 85% of all construction and basic training will have been completed by the sixth month of the fourth year so that at least one year of "steady state" operations has occurred prior to the end-of-project evaluation; 90% of existing workers have received a second "refresher" training course; and the management information system is functioning.

In the final project year, all outputs will have been achieved and the end-of-project evaluation held.

C. EVALUATION PLAN

The evaluation plan has, in addition to routine monitoring of progress in achieving the planned output targets, four main components: baseline studies, annual review, mid-project evaluation, and end-or-project evaluation.

The baseline studies have as their main purpose the establishement of benchmark indicators. The end-of-project evaluation will compare the selected indicators with the benchmarks to assess changes likely to be attributable to the Project. The main focus of the baseline studies will be to make estimates of goal and purpose indicators. Goal indicators may be measured directly, perhaps on a sampling basis. In any case, indirect goal indicators such as contraceptive prevalence will be measured. Other selected data such as contraceptive availability will be gathered and the use of control groups will be considered. The baseline information gathering will be planned by the states, the GOI, and USAID.

The annual review will rely on existing data derived from the monitoring process and on selected field visits. Its purpose will be to assess the progress of the project toward stated objectives and suggest changes based on increased knowledge in Project-assisted districts. The first annual review will occur following the completion of the needs assessment and the development of detailed state action plans.

The mid-Project evaluation may include selective special data gathering on some of the benchmarks that are deemed important and may include other studies based on perceived needs of project managers and monitors. The purpose of the mid-Project review is two-fold. The first purpose is for making moderate/major changes in project design based on the data and experiences of the project at that point in time. The second purpose is to assist the GOI and USAID in planning future bilateral projects.

The end-of-project evaluation will assess whether the purposes have been achieved and will be done in the last year of the Project life.

D. CONDITIONS AND CONVENANTS

In addition to the standard Conditions Precedent, the Project Agreement will include the following Conditions Precedent and Covenants:

1. Conditions Precedent to Disbursement for Construction

Prior to any disbursement for individual construction activities under the Grant, or to the issuance by A.I.D. of documentation pursuant to which such disbursement will be made, the cooperating country shall, except as A.I.D. may otherwise agree in writing, furnish in form and substance satisfactory to A.I.D. (1) detailed drawings and specifications for all types of buildings to be constructed, and (2) evidence that any newly constructed, improved or expanded facility is "operational", that is: has workers in place with adequate supplies and equipment and renders the intended services.

2. Covenants

Except as A.I.D. may otherwise agree in writing, the cooperating country will:

(1) Cause each state assisted by the project to establish special Project Offices at the state and district levels to manage and implement the Project.

(2) Ensure that no portion of grant proceeds will be attributed to motivation fees to any person for family planning or attributed to sterilization or abortion-related costs.

(3) Ensure that all family planning services, including sterilization, will be provided on a strictly voluntary basis.

INCOMING 25 JUL 1979 Proj. 386-0468

VV ND0291
PP RUEHND
DE RUEHC #2599 2060516
ZNR UUUUU ZZH
P 242225Z JUL 79
FM SECSTATE WASHDC
TO AMEMBASSY NEW DELHI PRIORITY 9949
BT
UNCLAS STATE 192599

Attachment A

7/26/79
12:30
ACTION
PRO-3
INFO:
PRO
CO
AAP
CHRON

negotiated

AIDAC

E.O. 12065: N/A

TAGS:

SUBJECT: INDIA - INTEGRATED RURAL HEALTH AND POPULATION PROJECT (386-0468) - PID REVIEW, JULY 6, 1979

1. THE APAC APPROVED THE PID AND AUTHORIZED THE MISSION TO PROCEED WITH PREPARATION OF A PROJECT PAPER FOR FY 80 FUNDING. THE IEE NEGATIVE DETERMINATION WAS ACCEPTED.

2. APAC ENDORSED THE INDIAN VIEW THAT HEALTH AND FAMILY PLANNING SERVICES CAN AND SHOULD BE INTEGRATED IN ONE SYSTEM FOR DELIVERY AND PROMOTION AT THE COMMUNITY LEVEL IN INDIA.

3. AN ESSENTIAL CONDITION FOR APPROVAL OF THE PROJECT WILL BE ITS DEMONSTRATION (A) THAT THE COMMUNITY HEALTH WORKER (CHW) PROGRAM WORKS, I.E., DELIVERS HEALTH CARE AND FAMILY PLANNING ASSISTANCE THROUGHOUT VILLAGES; AND (B) THAT UNDERWRITING FACILITIES AT A HIGHER LEVEL WILL BE BOTH CRUCIAL TO AND EFFECTIVE IN THIS.

4. APAC RECOGNIZED HOW LIMITED CURRENT KNOWLEDGE OF CHW EFFECTIVENESS IS AND EXPECTS THAT DESIGN WILL EXPAND ON THIS ADEQUATELY FOR PURPOSES OF PROJECT APPROVAL. ON THIS POINT, PP SHOULD INCLUDE, FOR THOSE INDIAN STATES SELECTED FOR AID ASSISTANCE, A PRELIMINARY EVALUATION OF PROGRAM SUCCESS SINCE 1978.

5. THE APAC BELIEVED THAT THE POSSIBILITY OF FUNDING ALL OR PART OF THIS PROJECT BY LOAN INSTEAD OF GRANT SHOULD BE EXPLORED WITH THE GOI. THE DESIRABILITY OF ONE OR THE OTHER FORM OF FUNDING OR A MIX OF THE TWO WOULD PRESUMABLY TURN ON THE FINAL FORM OF THE PROJECT AND THE DISTRIBUTION OF FUNDING AMONG CONSTRUCTION, TRAINING, COMMODITIES AND OTHER POSSIBLE COMPONENTS.

OFFICIAL FILE COPY

6. THE APAC UNDERSTOOD THAT SUCH DISTRIBUTION OF FUNDING AMONG COMPONENTS WILL BE SUBJECT TO ADDITIONAL NEGOTIATION WITH GOI. APAC WISHED TO RECORD ITS DESIRE THAT THE MAXIMUM POSSIBLE CONTENT BE AGREED TO THAT CONTRIBUTES DIRECTLY TO VILLAGE LEVEL HEALTH AND FAMILY PLANNING IMPROVEMENT. THIS WOULD INCLUDE PERHAPS TRAINING, ORAL CONTRACEPTIVE PROMOTION AT THE HOUSEHOLD LEVEL, AND EXTENSIVE PROJECT MONITORING AT THE VILLAGE SCALE. IT WAS RECOGNIZED, HOWEVER, THAT CONSTRUCTION OF BUILDINGS CAN REPRESENT AN IMPORTANT LINK IN THE CHAIN LEADING TOWARD A GOAL OF FERTILITY REDUCTION: THIS SHOULD BE DEMONSTRATED IN THE PP'S ANALYSIS OF THE INTEGRATED DELIVERY SYSTEM.

7. THE BALANCE OF 50:50 HEALTH AND FAMILY PLANNING FUNDING OF THE PROJECT WAS VIEWED BY APAC AS ACCEPTABLE. BUT IT WAS AGREED THAT DESIGN OF THE PROJECT, WHEN FINAL, MAY REQUIRE MODIFICATION OF THIS BALANCE IN LOP TERMS AND IN THE DISTRIBUTION AMONG YEARS. THE MISSION SHOULD NOTE, HOWEVER, THAT WHILE CONGRESSIONAL REPORTS ENCOURAGE INTEGRATED HEALTH DELIVERY PROGRAMS, THE FAA DOES NOT SPECIFY THE PERCENTAGES THAT MUST BE DEVOTED TO EITHER HEALTH OR FAMILY PLANNING.

8. IT WAS REITERATED DURING THE MEETING THAT AID PROVISION OF LAPAROSCOPES UNDER THIS OR ANOTHER PROJECT IS UNDERSTOOD TO BE DESIRED BY THE GOI, PERHAPS AT A COST OF DOLS. 4 MILLION FOR 1,000 OF THEM. THIS MAY BE PURSUED BY THE DESIGN TEAM. USE OF VOLAGS AT VILLAGE LEVELS SHOULD ALSO BE EXPLORED.

9. FIELDING OF A HIGHLY QUALIFIED DESIGN TEAM WAS REGARDED BY THE APAC AS KEY TO RAPID AND EFFECTIVE DEVELOPMENT OF THIS PROJECT. PROPOSED PLANS ON THIS

FOLLOW SEPTEL. APAC CONCLUDED THAT THE PRESENCE OF A DIRECT-HIRE USAID/NEW DELHI HEALTH/FP OFFICER ON THE DESIGN TEAM AND ON BOARD IN THE MISSION WILL BE CRUCIAL TO DEVELOPMENT OF THE PROJECT. WATCH
BT
#2599

Attachment B

I N D I A

INTEGRATED RURAL HEALTH & POPULATION PROJECT

CERTIFICATION PURSUANT TO SECTOR 611(e) OF THE FOREIGN ASSISTANCE ACT OF 1961, AS AMENDED

I, Priscilla Boughton, principal officer of the U.S. Agency for International Development in India, having taken into account among other things the maintenance and utilization of projects in India previously financed or assisted by the United States, do hereby certify that in my judgment India has the capability (both financial and human resources) to effectively maintain and utilize the Integrated Rural Health and Population Project.

Priscilla Boughton

Priscilla Boughton, Mission Director
USAID/India

5/23/80

Date

Attachment C

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

PROJECT AUTHORIZATION

INDIA

Integrated Rural Health and Population
Project No. 386-0468

Pursuant to Section 104 of the Foreign Assistance Act of 1961, as amended (the "Act"), and the Delegations of Authority thereunder, I hereby authorize the Integrated Rural Health and Population Project (the "Project") for India (the "Cooperating Country"), involving planned obligations of not to exceed Forty Million United States Dollars ($40,000,000) in grant funds over a three year period from date of authorization, subject to the availability of funds in accordance with the Agency for International Development (A.I.D.) OYB/allotment process, to help in financing foreign exchange and local currency costs of the Project. Of the above amount, not to exceed Thirteen Million Eight Hundred Thousand United States Dollars ($13,800,000) are authorized for population activities under Section 104(b) of the Act and not to exceed Twenty-Six Million Two Hundred Thousand United States Dollars ($26,200,000) are authorized for health activities under Section 104(c) of the Act.

The Project consists of assistance to the Cooperating Country in implementing its Model Plan for basic health and family planning services in 13 districts, selected on the basis of economic and health related "backwardness" criteria, in five states (Maharashtra, Gujarat, Punjab, Haryana and Himachal Pradesh). Project outputs will include (1) additional trained workers, (2) additional service facilities and quarters constructed, (3) additional person-years of work, (4) improved and expanded services, (5) improved and expanded training support, (6) improved and expanded communications support, (7) improved and expanded existing service facilities, and (8) improved and expanded management support.

Project inputs include technical and managerial skills of Cooperating Country institutions and professionals. The Cooperating Country will contribute Twenty-Four Million Seven Hundred and Forty-Five Thousand Dollars ($24,745,000) equivalent in local currency for project activities. Due to the construction component and time required for management systems development, a five year disbursement period will be necessary.

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

a. Source and Origin of Goods and Services

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

b. Conditions Precedent to Disbursement for Construction

Prior to disbursement for individual construction activities under the grant, or to the issuance by A.I.D. of documentation pursuant to which such disbursement will be made, the Cooperating Country shall, except as A.I.D. may otherwise agree in writing, furnish in form and substance satisfactory to A.I.D. (1) detailed drawings and specifications for all types of buildings to be constructed, and (2) evidence that any newly constructed, improved or expanded facility is "operational", that is: has workers in place with adequate supplies and equipment and renders the intended services.

c. Covenants

Except as A.I.D. may otherwise agree in writing, the Cooperating Country will:

(1) cause each state assisted by the Project to establish special Project Offices, at the state and district levels to manage and implement the Project;

(2) ensure that no portion of Grant proceeds will be attributed to motivation fees to any persons for family planning or attributed to sterilization or abortion-related costs; and

(3) ensure that all family planning services, including sterilization, will be provided on a strictly voluntary basis.

Clearances	Date	Initial
AA/ASIA, John H. Sullivan	8/20/80	JHS
A/GC, Charles Costello	8/20/80	GC
AA/PPC, Alexander Shakow	8/20/80	AS

Douglas J. Bennet, Jr.
Administrator

Aug 21/80
Date

ASIA/PD/SA:JOsborn;GC/ASIA:HMorris:jk/fv:8/18/80:58450

UNCLASSIFIED

Department of State

INCOMING TELEGRAM

PAGE 01 NEW DE<17819 270558Z 047553 AID8918
ACTION AID-35

ACTION OFFICE ASPD-03
INFO AAAS-01 ASEM-01 ASBI-02 ASDP-02 CH6-01 FM-02 ASTR-01
AADS-01 DSHE-01 POP-04 CH8-01 RELO-01 MAST-01 0-00
/022 A2 X

INFO OCT-01 SSO-00 OES-09 NEA-07 /052 W
061155 270603Z /15

O 270414Z AUG 80
FM AMEMBASSY NEW DELHI
TO SECSTATE WASHDC IMMEDIATE 1623

UNCLAS NEW DELHI 17819

AIDAC

E.O. 12065: N/A
SUBJECT: INTEGRATED RURAL HEALTH AND POPULATION - GOI LETTER REQUEST

REF: (A) NEW DELHI 17744 (B) STATE 225918

FOLLOWING IS EXACT TEXT OF GOI LETTER REQUEST FOR ASSISTANCE FOR INTEGRATED RURAL HEALTH AND POPULATION PROJECT:

" AUGUST 26, 1980

DEAR MRS. BOUGHTON:

THE GOVERNMENT OF INDIA HEREBY REQUEST A GRANT FROM THE GOVERNMENT OF THE UNITED STATES IN THE AMOUNT OF DOLS23.7 MILLION TO ASSIST IN FINANCING THE INTEGRATED RURAL HEALTH AND POPULATION PROJECT. THESE FUNDS ALONG WITH FURTHER US ASSISTANCE OF DOLS16.3 MILLION AS WELL AS THE GOVERNMENT OF INDIA'S CONTRIBUTION IN THE AMOUNT OF DOLS24.745 MILLION WILL FINANCE THE COST OF IMPLEMENTATION OF GOVERNMENT OF INDIA'S MODEL PLAN FOR BASIC HEALTH AND FAMILY PLANNING SERVICES IN 13 DISTRICTS IN FIVE STATES (MAHARASHTRA, GUJARAT, PUNJAB, HARYANA AND HIMACHAL PRADESH).

WE WOULD APPRECIATE YOUR EARLIEST CONSIDERATION OF THIS REQUEST FOR ASSISTANCE.

SINCERELY,

(SIGNED)

YOGESH CHANDRA
JOINT SECRETARY
DEPARTMENT OF ECONOMIC AFFAIRS
MINISTRY OF FINANCE ".

BLOOD

UNCLASSIFIED

Draft Project Description For Project Agreement

The purposes of the Project are (1) to improve access to health and family planning services that promote fertility and mortality reduction and (2) to improve and expand the services and support systems of the Government of India's Model Health Plan (Model Plan). The Project will seek to accomplish these purposes in thirteen districts (Project Districts) in five states as listed below:

State	Districts
Himachal Pradesh	Hamirpur Kangra Sirmur
Punjab	Bhatinda Faridkot Sangrur
Haryana	Bhiwani Mohendergarh Sirsa
Gujarat	Bharuch Panch Mahals
Maharashtra	Osmanabad Parbhani

In addition, the Project will strengthen certain institutions in the five states that are not located in the Project Districts but support services in the Project Districts.

I. THE PROJECT

A. Purpose 1: Improved Access to Health & Family Planning Services

Access to health and family planning services that promote fertility and mortality reduction will be improved by the training of additional village-level workers called Community Health Volunteers (CHV's) and dais (traditional birth attendants) and additional subcenter-level workers called Female Multipurpose Workers (FMW's), Male

Multipurpose Workers (MMW's), and Lady Health Visitors (LHV's). Access will also be improved by the construction of additional sub-centers including quarters for females, primary health centers, rural family welfare centers, upgraded primary health centers, and LHV quarters. Access will also be improved by employing additional workers including FMW's, MMW's, LHV's, medical officers, and nurses.

B. Purpose 2: Improved and Expanded Services and Support Systems

1. Baseline Survey and Needs Assessment

For purposes of detailed project planning and for the establishment of baseline indicators for evaluation, a baseline survey and various needs assessments will be done in the first year of the Project. The needs assessments will be done in the first year of the Project. The needs assessment will include disease patterns, quality of services, training needs, communications needs, management needs, and a determination of the current availability of reversible methods of contraception and of critical drugs, supplies, and equipment needs for mortality reduction in children 0-4 years old. In addition, the baseline survey will measure selected indicators including the "objectively verfiable indicators" from part II:B of the Project Paper and contraceptive prevalence. Other mutually agreed indicators may also be measured as part of the baseline survey.

2. Services

Based on the results of the needs assessment, plans for the improvement of existing services will be made. In addition, other services will be field tested and made available through the Scheme when found suitable.

3. Training

The Project will provide for increased training space at PHCs, Upgraded PHCs, a Male Multipurpose Center and a Regional Family Planning Training Center. In some cases the space will be used for training in the field of female workers (field practice areas), and in other cases the space will be used for basic training of multi-purpose workers and village level workers and for inservice refresher training of all categories of workers at the Village, Subcenter and PHC levels. The space will also be used for conducting community information, education and communications meetings.

Based on the results of the needs assessment, plans will be made to train existing service workers, managers and trainers in selected subjects. If needed, training institutions will be strengthened in staff and skills so that training capability is improved. Innovative training approaches may be tried.

4. Communications

Based on the results of the needs assessment, communications support for health and family planning services will be expanded and improved. Training programs and materials with local culture-specific content, will be developed for inclusion in inservice refresher training and in basic training to improve the communications knowledge and skills of service workers particularly in the area of interpersonal communications. Existing orientation training camps for village leaders will be intensified and educational camps will be organized for block and district leaders to promote community involvement in health and family planning matters, particularly the latter. Field workers from state/GOI institutions and agencies other than health and family planning will also be trained in family planning motivation and education, and particular efforts will be made to incorporate improved training material into the National Adult Education Program in Project Districts.

Based on the results of the needs assessment, district and block extension educators may be trained in planning, operations management, and evaluation and the staffs of the districts increased so that the decentralization of communications management to the district level is effective.

5. Improved and Expanded Existing Service Facilities

The Project will provide for improvement and expansion of selected existing health and family planning facilities to improve the quality of their services. PHCs will be improved and expanded, including the addition of an operating theater and space for beds, so that they may provide better quality surgical and emergency care services and improved child care. Upgraded PHCs and Subdistrict Hospitals will be improved and expanded, including the addition of an operating theater and space for beds, so that they may provide better quality surgical, obstetric and emergency care services and improved acute and special care for children.

6. Improved and Expanded Management Support

In addition to the management training mentioned in B-3: Training, the Project will provide for improvement and expansion of health and family planning services management support by (a) improvement of monitoring of service and support system activities, (b) improved program operations by altering management procedures and patterns as appropriate and by conducting practical studies to improve program operations, and (c) evaluation of the impact of programs. Monitoring capability will be improved and expanded by developing management information systems

to monitor services and support systems performance with priority given to improvement of logistics management at the periphery. The systems developed will furnish timely reports in which data analysis has been done and information is displayed in a clear manner. These systems may require additional staff and training at the block, district, and state levels for proper implementation. In addition, management support capability will be improved by strengthening the capability of the districts and states in program operations by altering management procedures and patterns as appropriate and by the conduct of practical research studies related to program planning, program management, program evaluation, management training, and organization of services. Special attention will be given to improving knowledge about groups who utilize the government rural system at low levels and to strengthen the prediction of contraceptive demand. Impact evaluation capability will be improved by increased staffing of the Evaluation Cells at both state and district levels, by training of Evaluation Cell staff, and by participation of the Evaluation Cell staff in baseline surveys, needs assessment, analytical and innovative studies, and in the follow-up evaluation of the Project.

II. PROJECT IMPLEMENTATION

The Project will primarily be managed by the state governments with overall supervision by the GOI and monitoring by USAID.

1. Central Government

The MOHFW will be responsible for overall coordination of the Project and will insure that all terms of the Project Agreement are fully met. the MOHFW will appoint a senior officer of the rank of Joint Secretary as Central Project Coordinator. The MOHFW will also appoint a Central Project Advisory Committee, chaired by the Secretary or the Additional Secretary-cum-Commissioner for Family Welfare, which will meet yearly to review progress of the Project and to consider and approve plans for the ensuing year. A USAID representative will be a member of the Central Project Advisory Committee, and representatives from AID/Washington may be invited to attend its meetings.

2. State Level

At the state level, the state ministries of health and family welfare will be responsible for implementing the Project.

Each state will appoint a senior officer of the rank of Special or Joint Secretary as Project Director with responsibility for all aspects of the Project. The Project Director will have a staff paid from Project funds, including a Planning and Implementation Cell, a Construction Cell and a Research and Evaluation Cell. Each state will appoint a Project Governing Board, chaired by the Chief Secretary of the state, that will meet quarterly to review the progress of the Project and to consider and approve plans for the ensuing quarter. USAID representatives will be invited to the meetings of the state Project Governming Boards.

3. District Level

At the district level, the Chief District Medical Officer will be responsible for implementing the Project. The Chief District Medical Officer will have a staff paid from Project funds, including a Planning and Implementation Cell, a Construction Cell, a Research and Evaluation Cell and a Communications Cell. Each state will appoint District Project Advisory Boards, chaired by the District Collector for Project-assisted Districts. In consultation with MOHFW, USAID representatives will make periodic visits to the Project districts.

4. Staffing

The GOI and the states will fill existing health and family planning services staff vacancies in Project Districts on a priority basis during the first year of the Project and will maintain optimum staff levels during the rest of the Project period.

5. Implementation Plan and Schedule

By the end of the first project year, the baseline surveys and needs assessments will have been carried out, the analyses done, and the reports submitted. Critical contraceptive supply and equipment needs relative to current or projected demand will have been determined and plans made to make needed items available on a priority basis. By the end of the second year of the project, supply and equipment system improvements will have occurred so that needed items are usually available.

III. PROJECT EVALUATION

The Project will provide for a Project Evaluation Plan which will have, in addition to routine monitoring of progress in achieving the planned output targets, four main components: (a) Baseline Studies, (b) Annual Review, (c) Mid-Project Evaluation and (d) End-of-Project Evaluation.

1. Baseline Studies

The Baseline Studies will have as their main purpose the establishment of bechmark indicators. The End-of-Project Evaluation will compare the selected indicators with the benchmarks to assess changes likely to be attributable to the Project. The Baseline information gathering will be planned jointly by the states, the GOI, and USAID.

2. Annual Review

The Annual Review will rely on existing data derived from the monitoring process and on selected field visits. Its purpose will be to assess the progress of the Project toward stated objectives and suggest changes based on increased knowledge in Project Districts. Particular importance will be given to assessment of progress in availability of reversible methods of contraception and of critical drugs, supplies, and equipment for mortality reduction in children 0-4 years.

3. The Mid-Project Evaluation may include selection special data gathering on some of the benchmarks that are deemed important and may include other studies based on perceived needs of project managers and monitors. The purposes of the Mid-Project Review are: (a) for making moderate/major changes in the Project design based on the data and experience of the Project at that point in time, and (b) to assist the GOI and USAID in planning future bilateral projects.

4. End-of-Project Evaluation

The End-of-Project Evaluation will assess whether the purposes of the Project have been achieved. It will be carried out in the last year of the Project.

PROJECT FINANCIAL PLAN
(Source and Application of Funding - $000s)

As of August ,1980

Project No. 386-0468(Grant)

PROJECT INPUTS	Cumulative Obligations/ Commitments as of August ,1980			Future Years anticipated			TOTAL		
	AID	GOI	OTHER	AID	GOI	OTHER	AID	GOI	OTHER
1. Construction & Initial Equipment	12,600	7,900	-	8,633	5,494	-	21,233	13,394	-
2. Salary Support	4,500	4,500	-	3,063	3,062	-	7,563	7,562	-
3. Training	2,300	-	-	1,483	-	-	3,783	-	-
4. Communications	600	-	-	373	-	-	973	-	-
5. Drugs	1,300	1,300	-	860	860	-	2,160	2,160	-
6. Research/Innovative/ Contingencies	1,500	-	-	938	-	-	2,438	-	-
7. Transport	-	1,000	-	-	629	-	-	1,629	-
8. Management Information Systems Development	500	-	-	550	-	-	1,050	-	-
9. Monitoring & Evaluation	300	-	-	281	-	-	581	-	-
10. Project Management	100	-	-	119	-	-	219	-	-
TOTAL	23,700	14,700	-	16,300	10,045	-	40,000	24,745	

5C(2) - PROJECT CHECKLIST

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

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

A. GENERAL CRITERIA FOR PROJECT

1. FY 79 App. Act Unnumbered; FAA Sec. 653 (b); Sec. 634A. (a) Describe how Committees on Appropriations of Senate and House have been or will be notified concerning the project; (b) is assistance within (Operational Year Budget) country or international organization allocation reported to Congress (or not more than $1 million over that figure)?	(a) Formal notification to Congressional Committees was given in AID's FY80 Congressional Presentation. Because of an increase in FY 80 funding, a Congressional Notification will be necessary prior to authorization. (b) No.
2. FAA Sec. 611(a)(1). Prior to obligation in excess of $100,000, will there be (a) engineering, financial, and other plans necessary to carry out the assistance and (b) a reasonably firm estimate of the cost to the U.S. of the assistance?	Yes
3. FAA Sec. 611(a)(2). If further legislative action is required within recipient country, what is basis for reasonable expectation that such action will be completed in time to permit orderly accomplishment of purpose of the assistance?	None
4. FAA Sec. 611(b); FY 79 App. Act Sec. 101. If for water or water-related land resource construction, has project met the standards and criteria as per the Principles and Standards for Planning Water and Related Land Resources dated October 25, 1973?	Not applicable
5. FAA Sec. 611(e). If project is capital assistance (e.g., construction), and all U.S. assistance for it will exceed $1 million, has Mission Director certified and Regional Assistant Administrator taken into consideration the country's capability effectively to maintain and utilize the project?	Yes
6. FAA Sec. 209. Is project susceptible of execution as part of regional or multilateral project? If so why is project not so executed? Information and conclusion whether assistance will encourage regional development programs.	No

A.

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

Not applicable

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

The project is not expected to foster private trade and investment abroad

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

India will contribute 38% of the total cost of the project. (see item 10 for U.S owned currencies)

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

Yes. The U.S - owned Indian rupees are being used for various USG agencies' program and administrative support.

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

Yes

12. FY 79 App. Act Sec. 608. If assistance is for the production of any commodity for export, is the commodity likely to be in surplus on world markets at the time the resulting productive capacity becomes operative, and is such assistance likely to cause substantial injury to U.S. producers of the same, similar, or competing commodity?

Not applicable-the assistance is not for the production of any commodity.

B. FUNDING CRITERIA FOR PROJECT

1. Development Assistance Project Criteria

a. FAA Sec. 102(b); 111; 113; 281a. Extent to which activity will (a) effectively involve the poor in development, by extending access to economy at local level, increasing labor-intensive production and the use of appropriate technology, spreading investment out from cities to small towns and rural areas, and insuring wide participation of the poor in the benefits of development on a sustained

A major purpose of this project is to improve access to basic health and family planning services by the rural poor. The project seeks to train and use a large number of community-based volunteers and multipurpose health workers for

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

the delivery of services in rural areas. More than one half of these workers will be women. The project is aimed at improving the health status of the rural poor, particularly women and young children.

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

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

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

The project emphasizes low-cost integrated health, population and nutrition delivery approach through the use of community-based volunteers and multipurpose health auxiliaries. A major focus of the project is on mothers, infants and young children. The project will also finance innovative lowcosthealth delivery.

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

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

(i) technical cooperation and development, especially with U.S. private and voluntary, or regional and international development, organizations;

(ii) to help alleviate energy problems;

(iii) research into, and evaluation of, economic development processes and techniques;

(iv) reconstruction after natural or manmade disaster;

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

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

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

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

Yes. GOI will contribute approximately 38% of all expenditures of the project.

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

This is a five year project. Justification has been provided in the Congressional Notification. No other donor financing is available.

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

The project addresses the need for basic health care and family planning services in rural areas and will strengthen local institutional capability to provide effective services for the benefit of the rural poor.

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

By improving the health status of the people, the project is expected to contribute indirectly to increased productivity.

2. Development Assistance Project Criteria (Loans Only)

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

Not applicable

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

Not applicable

3. Project Criteria Solely for Economic Support Fund

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

Not applicable

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

Not applicable

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

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

A. Procurement

1. FAA Sec. 602. Are there arrangements to permit U.S. small business to participate equitably in the furnishing of goods and services financed?	No imports from U.S or other countries are envisaged.
2. FAA Sec. 604(a). Will all commodity procurement financed be from the U.S. except as otherwise determined by the President or under delegation from him?	All commodities will be procured locally within the country.
3. FAA Sec. 604(d). If the cooperating country discriminates against U.S. marine insurance companies, will agreement require that marine insurance be placed in the United States on commodities financed?	Not applicable
4. FAA Sec. 604(e). If offshore procurement of agricultural commodity or product is to be financed, is there provision against such procurement when the domestic price of such commodity is less than parity?	Not applicable
5. FAA Sec. 608(a). Will U.S. Government excess personal property be utilized wherever practicable in lieu of the procurement of new items?	Not applicable
6. FAA Sec. 603. (a) Compliance with requirement in section 901(b) of the Merchant Marine Act of 1936, as amended, that at least 50 per centum of the gross tonnage of commodities (computed separately for dry bulk carriers, dry cargo liners, and tankers) financed shall be transported on privately owned U.S.-flag commercial vessels to the extent that such vessels are available at fair and reasonable rates.	Not applicable
7. FAA Sec. 621. If technical assistance is financed, will such assistance be furnished to the fullest extent practicable as goods and professional and other services from private enterprise on a contract basis? If the	No technical assistance is envisaged under the Project.

facilities of other Federal agencies will be utilized, are they paritcularly suitable, not competitive with private enterprise, and made available without undue interference with domestic programs?	
8. International Air Transport. Fair Competitive Practices Act, 1974. If air transportation of persons or property is financed on grant basis, will provision be made that U.S.-flag carriers will be utilized to the extent such service is available?	Yes
9. FY 79 App. Act Sec. 105. Does the contract for procurement contain a provision authorizing the termination of such contract for the convenience of the United States?	Not applicable
B. Construction	
1. FAA Sec. 601(d). If a capital (e.g., construction) project, are engineering and professional services of U.S. firms and their affiliates to be used to the maximum extent consistent with the national interest?	Construction of only small buildings are envisaged. Adequate capability exists within the country for such construction.
2. FAA Sec. 611(c). If contracts for construction are to be financed, will they be let on a competitive basis to maximum extent practicable?	Yes
3. FAA Sec. 620(k). If for construction of productive enterprise, will aggregate value of assistance to be furnished by the United States not exceed $100 million?	Not applicable
C. Other Restrictions	
1. FAA Sec. 122 (e). If development loan, is interest rate at least 2% per annum during grace period and at least 3% per annum thereafter?	Not applicable
2. FAA Sec. 301(d). If fund is established solely by U.S. contributions and administered by an international organization, does Comptroller General have audit rights?	Not applicable
3. FAA Sec. 620(h). Do arrangements preclude promoting or assisting the foriegn aid projects or activities of Communist-bloc countries, contrary to the best interests of the United States?	Yes
4. FAA Sec. 636(i). Is financing not permitted to be used, without waiver, for purchase, long-term lease, or exchange of motor vehicle manufactured outside the United States, or guaranty of such transaction?	Yes

C.

5. Will arrangements preclude use of financing:

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

Attachment F

AID 1020-26 (11-70)

PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

Life of Project: From FY 80 to FY 85
Total U. S. Funding $40
Date Prepared: May 1980

Project Title & Number: Integrated Rural Health and Population 386-0468

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
Program or Sector Goal: The broader objective to which this project contributes: (A-1) To reduce fertility in the population and mortality in the 0-4 age group.	Measures of Goal Achievement: (A-2) 1.A significant decline in the Crude Birth Rate. 2.A 15% decline in the Infant Mortality Rate. 3.A 20% decline in the 1-4 mortality rate.	(A-3) Baseline and end-of-project survey on a sampling basis with selected control groups.	Assumptions for achieving goal targets: (A-4) Increased access to improved and expanded services will lead to increased utilization of village-level and government services and hence to decreased fertility and mortality.
Project Purpose: (B-1) To improve access to health and family planning services that promote fertility and mortality reduction and to improve and expand the services and support systems of the Model Plan	Conditions that will indicate purpose has been achieved: End-of-Project status. (B-2) See purpose boxes, Part II: B of PP, pages 8-20.	(B-3) Baseline and end-of-project survey	Assumptions for achieving purpose: (B-4) The facilities will be constructed and the trained workers deployed so that the Model Plan organizational pattern is achieved and access is improved.
Project Outputs: (C-1) 1.Additional trained workers, 2.Additional service facilities and quarters constructed, 3.Additional person-years of work, 4. Improved and expanded services, 5.Improved and expanded training support, 6.Improved and expanded communications support, 7. Improved and expanded existing service facilities, 8.Improved and expanded management support.	Magnitude of Outputs: (C-2) See pages 17-20 of Project Paper	(C-3) Baseline survey, quarterly reports, end-of-project survey.	Assumptions for achieving outputs: (C-4) There are enough skilled project management staff to manage the project and the policies of the GOI and states about the Model Plan don't change significantly.
Project Inputs: (D-1) Technical and managerial skills of project staff and financial input of $64.7 million of which AID will contribute not more than $40 million.	Implementation Target (Type and Quantity) (D-2) Local costs only	(D-3) Not applicable.	Assumptions for providing inputs: (D-4) The Project Agreement between the Government of India and the United States government is signed and followed.

AGENCY FOR INTERNATIONAL DEVELOPMENT

Integrated Rural Health & Population Project

PROJECT PAPER ANNEXES

AUGUST 1980

USAID/INDIA

USAID/INDIA

Annexures to

Integrated Rural Health And Population Project

Project Paper

Annexure

1	-	Analysis and General Description of the Integrated Rural Health and Population Project (386-0468), September, 1979
2	-	Government of India Population Policy Statement
3	-	Government of India Draft National Health Policy
4	-	Government of India Model Health Plan for Donor Assisted Area Programs
5	-	Project District Profiles & Maps
6	-	Detailed Engineering Analysis
7	-	Financial Tables
8	-	Government of India/State Administrative Arrangemets for Project Implementation
9	-	Detailed Implementation Plan

Annex 1

ANALYSIS AND GENERAL DESCRIPTION

OF THE

INTEGRATED RURAL HEALTH AND POPULATION PROJECT (386-0468)

USAID Mission to India
New Delhi
September 1979

PREFACE

The report which follows was prepared by a joint team comprised of members from the USAID Mission to India, AID/Washington, and consultants. Its purpose is to present the basic framework for a Project Paper to be prepared by USAID/New Delhi for submission to AID/Washington during Fiscal Year 1980. The paper is intended to be of use to three different audiences: the Government of India, particularly the Ministry of Health and Family Welfare, and the governments of the States of Maharashtra, Gujarat, Haryana, Punjab, and Himachal Pradesh; various offices in AID/Washington; and the A.I.D. Mission to India. Washington readers are advised that this paper makes no effort to deal with all issues that must be covered in a Project Paper. It is still too early to specify precise inputs, for example, or to lay out an implementation plan.

The report is in two parts. The first is a fairly concise description of the project as it is currently envisioned, a social soundness assessment, and a discussion of technical issues. The second part* is a detailed discussion of the team's observations of current health and family welfare (family planning) program activities in the five states the Government of India is asking A.I.D. to assist. Appended to this report (for the AID/W audience only) is a copy of the summary of a major evaluation of the rural health system which was carried out by the National Institute of Health and Family Welfare in collaboration with six other Indian institutions. The findings of the evaluation are remarkably similar to those of the A.I.D. team -- a point which is worth emphasizing because we did not have access to the evaluation report until after our field visits had been completed.

Two questions of major importance have dominated our thinking as we have gone about preparing this report. Both were raised during AID/Washington reviews of this project at earlier stages in its development:

1. Is India's rural health delivery scheme providing health and family planning services at the village level?

*Not included in this attachment.

2. Is the construction of a large number of rural health facilities likely to make a major contribution to improving health care and health status and lowering fertility in the project areas?

We have sought to provide answers to these questions in the report that follows. Our basic conclusions are that the rural health delivery scheme, including the Community Health Volunteer concept, is technically and sociologically sound; that improvements in program implementation based on this concept are necessary if it is to yield important dividends in terms of mortality, morbidity, and fertility; and that construction of domiciliary and outpatient facilities at the periphery of the system is likely to contribute substantially to the success of the program and the project.

This report was prepared by the following individuals:

Anne Aarnes, Program & Policy Coordination Bureau, AID/Washington
P. E. Balakrishnan, Health, Population & Nutrition Office, USAID/New Delhi
Peter Bloom, Capital Development Office, USAID/New Delhi
P. Diesh, Capital Development Office, USAID/New Delhi
Gladys Gilbert, Health, Population & Nutrition Office, USAID/New Delhi
Allen Jones, Consultant, American Public Health Association (APHA)
Y. P. Kumar, Capital Development Office, USAID/New Delhi
John W. Lesar, Health, Population & Nutrition Office, USAID/New Delhi
Steven W. Sinding, Asia Bureau, AID/Washington
Joe D. Wray, APHA Consultant, Harvard School of Public Health

We wish to express our deep thanks to Smt. Serla Grewal and her staff at the Ministry of Health and Family Welfare, New Delhi, and to officials of the five state governments for their unfailing cooperation and their kind hospitality -- and most especially for their forbearance in the face of what must have seemed an unending stream of questions and demands for information. Special thanks go to those Central and state officials who spent many hours of their own time escorting us during our field visits.

New Delhi
Sept. 26, 1979

PART I

PROJECT BACKGROUND AND GENERAL DESCRIPTION

A. BACKGROUND

Providing basic health care to all its citizens has been a major objective of the Indian Government ever since the country's Independence in 1947. During the last 30 years or so, 5,400 primary health centers -- one in each development block, covering a population of 80 - 100,000 -- and some 40,000 sub-centers -- one for every 10 - 12,000 population -- have been established throughout the country. In addition to these impressive accomplishments, India has built a vast array of hospitals, dispensaries, clinics and other medical facilities.

Several major communicable diseases which claimed millions of lives in the early part of this century, have been brought under control. Smallpox, a dreaded killer disease, has been eliminated from the country. All of these developments have resulted in a dramatic reduction in the country's crude death rate, from about 38 per 1,000 in 1920 to 15 per 1,000 currently. The infant mortality rate, another important index of a community's health status, was also reduced, although less dramatically, from 200 to 125, during the same period. As a result, the average expectation of life at birth in the country has increased from 20 years in 1920 to 50 years today.

Although these are no mean achievements by any standard, the current health situation in India is far from satisfactory. Indeed, the general and infant mortality rates mentioned above are still among the highest in the world and are at least twice as high as in some other Asian countries such as Sri Lanka, Malaysia, Singapore, and Taiwan. What is more significant than these relatively high mortality rates, however, is the fact that there are glaring disparities in the status of health between the urban and rural areas of the country. Thus, for example, while the death rate in the urban areas is 9 per 1,000, it is as high as 16 in the rural areas. Similarly, while the infant mortality rate in the urban areas is about 75, it is nearly 140 in the rural areas. Also, the life expectancy in urban areas is around 60 while it is only about 47 in rural areas. There are significant differences in these vital rates among the various states in the country.

One of the important reasons for these striking differences is the lopsided development of health facilities in the past. The rural areas account for 80 percent of the total population of the country, but according to the Government's own estimate, nearly 75% of all inputs in the health field are currently deployed in the urban areas, which represent only 20 percent of the population. The primary health center complex in the rural areas, with its existing sub-centers, is able to cover at best only 15 - 20 percent of the total population in a block, leaving the remaining 80 - 85 percent of the population without the benefit of even the most minimal health care.

These disparities in mortality rates and health care facilities show that despite the achievements of the past, the Government is yet to provide a large segment of the underprivileged population living in the rural areas, particularly young children and mothers who claim a large proportion of the morbidity and mortality in these areas, the same access to health and life as is provided to the more privileged urban population.

India is also facing a serious population problem. The country has the second largest population in the world -- estimated at over 650 million in 1979. It is growing at the rate of 2 percent per annum and will cross the one billion mark before the end of the century unless a rapid reduction in the birth rate occurs through organized family planning efforts.

The Government of India is deeply aware of the consequences of this rapid population growth. In fact, India was among the first countries in the world to launch an official family planning program. It began in 1952 as part of the economic and social development plan. Between 1952 and 1978, over 30 million sterilizations and 7 million IUD insertions were performed in the country. More than 3 million users of condom were enrolled. However, the birth rate is still relatively high : 33 per thousand and the program is yet to make very much of an impact in the rural areas. Because of the political back-lash occasioned by acknowledged excesses in the sterilization program during 1975-76, the program was set back substantially in 1977 and 1978. It has yet to even reach the pre-1976 levels of sterilization. The Government is keenly aware of these facts and has set about revitalizing the program on the basis of strict voluntarism. While

the road back will be difficult, the Government has shown considerable determination through recent decisions to more actively promote the use of the oral contraceptive and to continue to give high priority to family planning in the basic health services program. Major efforts in the use of mass media and interpersonal communication for family planning are also in the works. India continues to search for solutions to its acknowledged population crisis.

The Government of India has worked to improve the balance between urban and rural health and family planning services consistently over the past years. This is now manifested in the National Minimum Needs Program which is intended to influence all sectors of government action. In health and family welfare, the National Minimum Needs Program is expressed through the Comprehensive Rural Health Program which is based on the following model:

MODEL SCHEME

Level of Care	Providers	Population Served
Village	CHV, trained dai	1,000 people
Several villages (3-8) via subcenter	Auxiliary Nurse Midwife (ANM) and male multi-purpose worker (MPW)	5,000 people
Community development block via Primary Health Center (PHC)	doctors, Lady Health Visitors (LHV), ANM's, Health Assistants (H.A.s)	100,000 people
Upgraded PHCs/ Sub district hospitals	doctors, nurses	Variable but about 300,000 - 400,000 people
District Hospitals	doctor specialists nurses	million people plus

In addition, government dispensaries are often found below the PHC level but above the subcenter level. These facilities are to be strengthened and upgraded as necessary.

This service infrastructure is meant to "bring health care to the doorstep of the people" and reflects the policy consensus of Alma-Ata, as expressed by the World Health Organization, to "bring health to all by the year 2000."

The services infrastructure is not yet in place at the desired levels of manpower. At the village level, implementation varies from state to state. At the subcenter level, many states now have one subcenter for 10,000 people with one ANM as the resident worker. Thus, in these states implementation of the Comprehensive Rural Health Program means a doubling of the number of subcenters (to reach a 1 : 5000 population ratio) and a quadrupling of personnel at the subcenter level by the addition of a male multipurpose worker to complement the role of the ANM.

The services infrastructure is supported by a management training infrastructure. The management infrastructure begins in theory at the village level with "village-level" administrative supervision by the panchayat or village council. The subcenter is supervised by the Primary Health Center through the LHVs, Health Assistants (HAs), and medical officers. The PHC is supervised by the district health officer and his staff who then either report to the state Director of Health Services or through an intermediate supervisor called, in some states, a divisional health officer. The states are responsible for health matters, under the Indian Constitution, with overall policy guidance from the Government of India through the Ministry of Health and Family Welfare. The Central Government retains full control of family planning activities.

B. GENERAL DESCRIPTION OF THE PROJECT

This project will assist the Government of India in the implementation of its model scheme. The project will focus on selected districts in up to five states of the country. In accordance with policies of both the Government of India and the United States Government, the project has the specific goals of improving the health and family welfare of the rural poor with emphasis on the rural woman of childbearing age and the young child under age five years. In more operational terms, the project seeks to accomplish the following goals:

1. Reduce mortality, especially of children under the age of five and women of child-bearing age

2. Reduce fertility

3. Reduce morbidity, especially of mothers and children, particularly that associated with diarrheal, respiratory, and immunizable conditions and exacerbated by malnutrition.

To accomplish these goals, following the model health scheme of the Government of India, the project will have the following purposes:

1. To improve access to basic health, population, and nutrition services by assisting the GOI in the more rapid implementation of the scheme, particularly at the village and subcenter levels in the selected districts.

2. To expand the kinds of services offered under the model scheme after thorough analysis of the best approaches to reduce young child and maternal mortality and fertility within the context of the model scheme and of the socio-cultural environment of the areas selected.

3. To improve the quality of existing services offered within the context of the model scheme specifically those of fertility and maternal and child mortality.

4. To improve the utilization of services by young children and women of child-bearing age with special attention to socially disadvantaged families.

C. MEANS TO ACHIEVE THE PURPOSES OF THE PROJECT

The first purpose of the project is to assist the government in improving rural access to basic health, population, and nutrition services. This will be accomplished by financial assistance in constructing rural subcenters and other facilities at a more rapid rate than would otherwise be possible, toward the targets established by the Government. In addition to construction financing, the project will assist the government in using the model scheme to increase access to care for groups that suffer from the highest rates of mortality and fertility -- the poor, in general, and young children and women, in particular. This will be accomplished by the

collection of baseline data and the establishment of an on-going management information system that will ascertain whether these target groups are being reached and are using the system in a way that is likely to lower their mortality and fertility. With such information, project managers will be in a position to make adjustments during the life of the project.

The second purpose of this project is to expand the kinds of services offered under the model plan that directly affect fertility and child and maternal mortality. This will be accomplished by a thorough review of the current technology that might be applied within the context of the model scheme. In addition, selected operational research studies might be necessary so that the existing behavior of villagers when they need advice or become sick is better known. This review and information gathering may result in modifications of existing service packages so that services contributing more directly to reductions in mortality and fertility are introduced or more fully emphasized. Particular attention will be paid to determining how to reach socially disadvantaged families who bear a particularly heavy burden of mortality and have very high fertility rates. Achievement of this purpose would augment and help to better focus existing services, but not replace them.

The third purpose of the project is to improve the quality of existing services offered within the context of the model scheme, especially services affecting child and maternal mortality and fertility. As noted in the technical analysis section of this report, many services are functioning adequately within the rural health system. Other services need improvement. Improvements will be made in various ways but should include support for the development of a periodic, on-going system for evaluating the skills of all rural health system workers who are dealing with young children and women of child-bearing age. The system will give information for the planning of continuing education programs for existing workers and for making modifications in the basic training of students who, after graduation, will enter the rural health system workforce. The project will support the developmental and start-up costs of the continuing education system and will support improvement in existing basic training institutions.

D. EXPECTED OUTPUTS OF THIS PROJECT

Quantifiable targets for the project will be developed over the next few months and incorporated into the Project Paper. It is possible now to indicate some categories of outputs expected from the project. These are expressed below.

PURPOSE 1: To improve access to basic health, population, and nutrition services by assisting the Government of India in the more rapid implementation of the model scheme in the selected districts.

Expected Outputs

1. An increased number of trained village-level workers in the project areas.

2. An increased number of "operational" subcenters in the project area.

3. An increased number of other service units in the project area if such units will contribute to the lowering of child mortality, maternal mortality, and fertility in the project areas (to be determined during the PP development process).

"Operational" subcenters are subcenters that are not only constructed but also equipped, staffed, and offering services that will contribute to program and project goals. For existing subcenters to become operational, many will require new buildings and equipment.

PURPOSE 2: To expand the kinds of services offered under the model scheme after thorough analysis of the best approaches to reduce young child and maternal mortality and fertility within the context of the model scheme and of the sociocultural environment of the areas selected.

Expected Outputs

1. Analyses completed
2. Innovative changes field tested
3. New kinds of services implemented
4. On-going monitoring system developed.

PURPOSE 3: To improve the quality of selected existing services offered within the context of the model scheme, specifically those affecting fertility and maternal and child mortality.

Expected Outputs

1. Skill evaluation monitoring system developed

2. Existing workers receiving periodic refresher training in skill areas contributing to the lowering of fertility and maternal and child mortality, including technical skills improvement and, where necessary, management skills improvement

3. Workers receiving improved basic training in skill areas contributing to the lowering of fertility and maternal and child mortality, including technical skills and, where necessary, management skills

PURPOSE 4: To improve the utilization of services by children and women of child-bearing age with special attention to socially disadvantaged families.

Expected Outputs

1. Increased contacts between well trained health services providers and children and women of child-bearing age.

E. INPUTS

It is not possible at this stage of project development to specify inputs in any great detail. To do so, it will be necessary to undertake far more comprehensive discussions with state officials and with officials of the Government of India. For the moment, we can identify seven general categories of inputs that are anticipated.

1. Construction/equipping of subcenters at specific locations to be determined, according to construction standards to be developed

2. As necessary, construction/improvement/equipping of higher level health institutions (PHCs, SHCs)

3. Development and implementation of a management information system to continually monitor project implementation

4. Establishment of a project evaluation system, including initial collection of baseline data

5. Operations research and demonstration activities/innovative activities

6. Evaluation of the training system and planning for revised training/retraining methodologies

7. Financing improvements in the training system, including teaching equipment, and curricular materials.

F. MAJOR ASSUMPTIONS

1. Linking inputs to outputs:

a. New and/or improved (and properly maintained) facilities at the subcenter level and higher will improve worker morale and will provide the means necessary to offer improved health and family planning services.

b. The Government of India, the state governments, and other Indian institutions have the will and the capability to establish and maintain a management information system to monitor project implementation.

c. The Government of India, the state governments, and other Indian institutions have the will and the capability to collect baseline data on health and family planning status and behavior and to measure these variables periodically thereafter in order to evaluate project effectiveness.

d. The Government of India, the state governments, and other Indian institutions have the will and the capability to identify important areas for operations research, demonstration, and innovative activities and to carry out such activities.

e. The Government of India and the state governments recognize the need to improve the training and retraining of health system workers and are prepared to evaluate the system to identify existing deficiencies, plan an improved system, and undertake the steps necessary to offer improved training/retraining.

2. Linking Outputs to Purpose:

a. Increased numbers of trained workers at all levels will lead to improved access to health and family planning services.

b. Improved/additional facilities, especially in the rural areas, will increase access to adequate health and family planning services.

c. Utilization of the management information system, operations research, demonstration projects, and innovative activities will lead to improvements in the types of services offered in attempting to lower fertility and maternal and child mortality.

d. Improved initial training and retraining/reorientation will lead to higher quality health and family planning services delivery.

3. Linking Purpose to Goal:

a. Increased access to health services will lead to increased utilization of services and hence to decreased fertility, and decreased mortality and morbidity among mothers and children under the age of five.

b. Improvements in the quality of services will lead to direct decreases in fertility, mortality, and morbidity.

c. Improvements in the types of services offered such that they are specifically oriented toward the major causes of high fertility, mortality and morbidity will lead to lower fertility, mortality, and morbidity.

SOCIAL SOUNDNESS ANALYSIS

Introduction

This social soundness analysis has been drafted with reference to the principal issues outlined in the model in the AID Handbook 3, Appendix 4-A. However, the analysis neither adheres strictly to the sequence of points made in Appendix 4-A nor treats in a specific way the questions raised in the first part of the Appendix because these initial questions are not especially germane to the discussion of this project. AID's integrated rural health and family planning project for India seeks to provide assistance for a system that has already been devised by the Government of India and which has 40 years of history behind it.* Thus, what is assumed in the early part of the Appendix, i.e. the introduction of a wholly new system, is not at issue in this project. The goal of India's health system -- taking "health care to the doorstep of the people"** --is consistent with AID's Congressional mandate. Furthermore, the Government of India, in designing the system over the years, has taken care to ensure that the health structure and delivery services is consistent with India's system of traditional values, beliefs, social structure and social organization. A clear example may be seen in the increasing respectability of and emphasis being given to traditional systems of medicine (i.e. ayurvedic,unani),*** demonstrated by the inclusion of a section on these systems in the Community Health Worker's manual. Another example is the provision for participation by the panchayat -- India's time-honored, local-level, democratic institution -- in the Community Health Volunteer (CHV) scheme. These examples are but two of several which might be cited to adequately respond to the initial Appendix questions. All of the issues raised in Appendix 4-A are addressed in the analysis that follows, though not necessarily in the order in which they are presented by the Appendix.

---

* See Bhore Committee Report, Government of India, 1946.

** See "Health Service At Your Doorstep", Ministry of Health and Family Welfare, Government of India, 1978.

*** Draft National Health Policy, Government of India, 1970.

One final note by way of introduction: this social soundness analysis draws heavily on observations made by the team during field visits. It attempts to summarize many of those observations. However, this brief summary can not do full justice to all of them. Thus, the reader is urged to refer to each of the social soundness analyses which appear in Part II of this report.

Community Health Volunteers as Community Workers

The uniform findings of three separate field visits by A.I.D. teams to the five Indian states (see Part II) reveal that the Community Health Volunteers are viewed as legitimate providers of health and family planning services by their communities and, as such, have experienced community-wide acceptance of their role and activities. These findings have been closely corroborated by two recent studies,* one of which is attached to this report.

The findings of the trip reports reveal that whereas many CHVs fall short of providing all of the services they have been trained or are supposed to provide, they have been accepted at least as local providers usually of some preventive services as well as of simple medicines for common ailments (i.e. colds, coughs, fevers, headaches). Immunizations, malaria detection, and family planning, are the preventive services the CHVs appear to spend most of their time providing. Less time is given to other preventive measures such as nutrition, environmental sanitation, and health education. To the extent that some CHV services have not yet made inroads into the village, the reasons have not to do with social taboos so much as inadequate CHV training and lack of village demand stemming from lack of health education.

Concerning the use of CHV services by different social groups in the community, the findings indicate that the CHVs are generally used by or are acceptable to all groups irrespective of class, caste, religion or community. This is, in large part, because the scheme was purposefully designed to incorporate workers from all levels of society. Still

---

* Repeat Evaluation of Community Health Volunteers' Scheme - 1979: A Collaborative Study: Summary, Conclusions and Recommendations. (National Institute of Health and Family Welfare: New Delhi, 1979), pp. 6-9.; Ashish Bose, et.al., An Assessment of the New Rural Health Scheme and Suggestions for Improvement. (Demographic Research Centre, Institute of Economic Growth: New Delhi, 1978), p. 7.

efforts need to be made (and are being undertaken) to recruit representatives from those groups (e.g. women, scheduled castes and tribes) which the scheme is still not reaching in adequate numbers. Often the wealthier classes of the community choose to seek health care outside the village, with the result that the CHVs serve mainly the middle and lower social groups in the community. However, if one looks at users of the system by age and sex, one finds considerable variation but generally less use by women, infants and young children. This finding is discussed at greater length below; suffice it to say here that to the extent that social forces contribute to this deficiency, they do not appear to constitute overriding obstacles to the scheme's potential to eventually embrace and benefit those groups.

Finally, mention should be made about traditional providers of health care in the village such as vaids and other traditional healers who constitute potential competitors to the CHV. The Government has thoughtfully integrated traditional and indigenous medical systems in the training of the CHVs and the states have been given the flexibility to include traditional medical aids in the kits used by the CHVs where the traditional systems are more prevalent. This seems to have increased receptivity to CHVs and hence, their effectiveness in the rural communities.

Selection, Performance and Linkages in the Scheme

Based on observations in the five states, it is clear that the government's criteria* for CHV recruitment have been found acceptable and are being followed. Selection of CHVs involves the village panchayat and, most often, the Primary Health Center (PHC) doctors. The panchayat normally selects three nominees and then forwards their names. The PHC doctors then select the best candidate after interviewing the three nominees. There are slight variations in the selection procedures among the states. However, the involvement of the panchayat in every state is significant because it contributes to the community's acceptance of the CHV and reinforces his/her legitimacy. On the other hand, the final selection of the CHV by the PHC doctors provides the initial link between the CHV and the larger health system.

---

* These include age (early thirties or older), sex (females preferred), occupation (some gainful employment), education (minimum 6th standard), and personal attitude (interest in social service).

The process of selection of CHVs seems to have a variable effect on both CHV acceptance and performance. Thus, for instance, shopkeeper CHVs tend to be more effective than farmers because they have contact with villagers throughout the day and are often more adept at interpersonal relations. A young, single male CHV is likely to be less effective than a woman in providing maternal and child health or family planning services. But in general, the selection process does have the support of both the community and the CHVs and is working well to locate and recruit appropriate workers.

Though the CHV policy states that the CHVs are to be responsible to and "supervised" by the village panchayat, we find that after his initial selection by the panchayat, neither the CHV nor the community sees a continuing relationship of control or supervision. On the other hand, the CHV in carrying out his functions develops a strong informal supervisory relationship with other workers in the health system. He assists the Multipurpose Worker (MPW) with MCH care such as immunizations in the village and looks to him or her for guidance. The CHV depends upon the PHC doctor for training, honorarium and medicines and in the matter of case referrals, he looks to the MPW and the doctors. Thus there are several forces at work drawing the CHV into the health structure and away from an employer-employee relationship with the village. We have concluded that this situation is likely to persist until the CHV's self-image changes from that of physician extender to community resource. The CHV's self-image, in turn, will depend upon his training and the community's expectations. We deal with these issues in greater detail below and in the field reports in Part II.

In contrast to the relationship between CHVs and workers at higher levels in the system, linkages between workers at the PHC and sub-center levels are well defined, formalized, and of long standing. On the whole, we found that workers seem to understand their respective roles and work together reasonably well; we observed no cases in which there was friction between workers at these levels. In some instances, a sense of "team spirit" and of commitment to public service was clearly discernible.

Aside from supervisory and advisory considerations, such issues as inadequate transportation, poor living quarters, and an absence of social outlets in rural areas are factors that affect somewhat adversely workers' morale and performance. In some cases, these factors lead to personnel seeking transfers but not with sufficient frequency to really weaken the system.

Use of Subcenters

According to the Government's plan, the subcenters are both clinics, serving the rural population's health and family planning needs, and support and operations bases for the ANM and MPW, enabling them to carry those services into the surrounding villages. We found that, in general, the subcenter is being used more as a base for outreach activities (e.g. immunizations, family planning motivation) than as a clinic; not many patients were seen during the various visits to the subcenters. Of the people who do come to the subcenter, most are from the immediate area, say within 3 kilometers. Very few seem to come from further away. Those who come tend to be from poorer families for whom it is either too difficult or too costly to travel to a larger, more distant health facility. Middle and higher income groups do not generally use the subcenter. Rather, they seek alternative sources of health care from larger facilities or from private doctors.

The arguments put forward by the Government to the effect that few people are using the subcenters because of their physical inadequacies and that the ANMs' services suffer because of a lack of adequate living quarters do make sense in the Indian context

From a social analysis standpoint, we are persuaded that constructed subcenters (as opposed to rooms donated or rented in the village) will greatly increase the probability that single women (ANMs) will stay and work in rural areas. Furthermore, as the following technical analysis makes clear, the project anticipates the introduction of certain forms of health care and family planning (i.e. IUD insertions) that will require the existence of such structures.

Social Factors Affecting Rural Health Services

As the findings in Part II show, there are important social factors that affect the health seeking behavior of the population. Among these are income, sex and age. Other socio-economic variables such as

caste, occupation, and religion, were found to have little effect in determining either worker effectiveness or village acceptability of the health system.

As we mentioned above, income does influence the health seeking behavior of patients. Those who can afford to will often not even use the Government's health system but will instead seek care from registered traditional practitioners or private physicians.*

The socio-cultural norm of sexual segregation appears to affect preference in seeking health and family planning assistance. Thus women prefer to seek care from female MPWs (ANMs) and men from male MPWs. Female MPWs are more acceptable as providers of service to children than male MPWs are. And, while men will accept care from female MPWs, women will not generally accept care from male workers.

Young children between the ages of 0 - 5, and to a lesser extent women, are not the beneficiaries of the health system to the extent they should be. Again, certain socio-cultural norms (e.g. the relative subordination, workload and immobility of rural Indian women and,by extension, their children) are at least part of the reason for this problem. Continued efforts along the lines the Government has recently initiated need to be supported to bring women into the health system as workers, especially as CHVs, in order to insure that health services are provided for all.

Our observations, corroborated in large measure by the NIHFW evaluation this year and the Ashish Bose report last year, suggest that the CHV represents a tremendous potential health resource. Today the CHV is serving largely as a dispenser of medicines. As such, he/she is doing some good for community health. However, the CHV is not bringing preventive health care to the village in the ways hoped for. The basic conclusion of this social analysis is that there are two fundamental reasons for this deficiency in the CHV Scheme. First, the CHVs are not properly trained in preventive and promotive care. The NIHFW makes that clear enough. Second, and we think more important, the CHV is probably giving the village the health care the

---

* Bose, p.13.

village thinks it wants and that most gratifies the CHV -- curative services. This is not likely to change until and unless (a) the CHV is required to do more preventive/promotive work, (b) he or she recognizes the importance of doing more on the preventive/promotive side, and (c) the community demands more attention to preventive and environmental health care. The first and second conditions can be changed by direct interventions in the training and management systems. Indeed, they are anticipated by the project. The third will only change over time as the result of improved health education and communication. In this too, the CHV can play an important role.

In conclusion, it can be said that the delivery system of health care and family planning services as presently designed and in operation is consistent with prevailing norms and practices and that we see no serious obstacles to the ability of the proposed project to provide effective health care and family planning services in rural India.

TECHNICAL ISSUES

Introduction

Since this project is intended to improve health and family planning services for the rural poor, the principal technical concerns focus on the parts of the health system through which most of those services are provided. These parts include the personnel and facilities at the sub-district level and below; doctors and paramedical personnel stationed at the primary health center (PHC) in each taluka; auxiliary nurse midwives (ANMs) who work out of subcenters; male multipurpose workers (MPWs), who cover several villages; and community health volunteers (CHVs) who work in their own villages. The analysis that follows addresses the main technical issues regarding the services these workers provide; the management and support they receive from the system (i.e. supervision, logistics, planning and evaluation); training; and the overall feasibility of the system and potential for strengthening it.*

Services for Priority Needs

Although health workers throughout the rural health system are trained to provide services that meet most priority health care and family welfare needs, gaps exist between training and actual provision of services. The gaps vary between levels of workers, from individual to individual, and from state to state.

CHVs organize for immunizations, do malaria detection and presumptive treatment, recognize and refer probable TB cases, chlorinate wells, motivate for family planning, and provide simple first aid and minor sickness care. Most of their time is spent on curative care, however. They concentrate on treating aches and pains, colds and sore throats, ailments that in the course of time heal or disappear with or without treatment. Considering that the CHV program was intended to stress preventive and promotive aspects of care, and that missing from the list are interventions that could more directly affect morbidity and

---

* Of course, the general conclusions which follow are based on only one week's field observations and the reading of various evaluation reports. We trust that readers will recognize that what follows is consequently offered with humility.

mortality, this finding is disturbing. The CHV manual includes discussions of antenatal care, assessment of growth and development of young children, diarrheal treatment, respiratory disease assessment, and recognition and treatment of malnutrition. But the CHVs devote little time to any of these problems.

Dais are trained to perform hygienic deliveries and motivate acceptors for family planning. They appear to do the former well, but less of the latter. They could be trained to perform more functions.

At the subcenter level, ANMs and MPWs are trained to provide a wider variety of services. Generally, ANMs seem to enjoy a more defined role and therefore provide more useful services than their male counterparts. MPWs, most of them recently converted from Unipurpose Workers, are still staff in search of a job. The USAID teams occasionally encountered MPWs who did not stray from the PHC premises, which raises questions about the extent to which they actually fulfill their assigned role in environmental sanitation, TB detection, and malaria detection and treament. On the other hand, ANMs do seem to perform several important tasks effectively: routine deliveries, postpartum care, motivation for tubectomy, and in certain states IUD insertions. Their impact on health and family welfare would probably be greater, however, if they devoted more attention to antenatal care, child spacing methods, malnutrition, and treatment of diarrheal diseases.

At the PHC level, many services are effectively performed and the facilities and personnel's time are fully utilized. Most outpatients come for minor sickness, first aid treatment and respiratory disease care. Sterilizations are performed for both men and women, routine deliveries handled, and immunization, TB, and malaria programs organized and carried out. Again, however, it appears that some important services are not being offered. These include emergency obstetrical care, care for severely malnourished children, antenatal care, child spacing services, and assessment of children's growth and development. In some states, the PHC doctors' visits to the subcenters also seem irregular.

The overall record of the rural health system in meeting priority health and family welfare needs thus appears mixed. Doctors in PHCs, ANMs, MPWs and CHVs do appear to reach the poor directly with services that address some important needs, while other important services could be considerably strengthened - e.g. treatment of diarrheal diseases and assessment or treatment of respiratory infections, the two principal causes of death in children under five. Concerted efforts at recognition and treatment of malnutrition are virtually lacking among all levels of workers. Promotion and use of non-permanent contraceptive methods -- oral contraceptives, condoms, IUDs -- receive only slight emphasis.

The rural health system in India currently appears to be used heavily by older children and males, with the exception of childhood immunizations. The National Institute of Health and Family Welfare's comprehensive evaluation of the CHV scheme points out that "pre-school children and women constitute a small percentage of the users of services of the CHVs". (p. 38) A similar conclusion may hold for the PHC level, except in the case of sterilization, which large numbers of women receive in PHCs. Trained dais and ANMs provide antenatal, delivery and postnatal services -- but otherwise women are not frequent users of the system. Young children under age five also appear to use the system infrequently. This certainly diminishes the ability of the system to affect young child mortality.

Family planning appears to hold a strong position in the rural health system, although the proportion of time each worker spends on family planning varies from state to state. CHVs and PHC doctors appear to be particularly actively involved in providing motivation and services, especially for sterilization. The CHVs in general are interested in family planning, view it as one of their most important responsibilities, and are among the most successful motivators in the system. However, there is an apparent lack of emphasis on spacing methods.

Planning and Evaluation

Planning and evaluation are essential to the operation of effective planned public health programs within an overall rural health system. Good planning first requires reliable data on fertility, mortality, morbidity and contraceptive prevalence. The Government of India and the state governments recognize the need to improve the data situation. More reliable data are needed, for example, on young child morbidity, and on what proportions of total health and family planning services are supplied through non-government programs.

The absence of these data makes it difficult to plan and evaluate the program. They particularly hamper the development of training/retraining to meet particular health and family planning needs, and formulation of specific objectives for each category of worker. As discussed below, ANMs and CHVs apparently have no concrete performance objectives in some important areas (e.g. treatment of diarrheal diseases, malnutrition, etc.). It is thus impossible to assess their work and plan program improvements. CHVs, as volunteers, are not assigned specific targets in any area, nor are they required to submit reports on their work. (The NIHFW evaluation found that most CHVs do in fact keep records, however -- a diary of people they treat, a family planning register, and a register for vital events.)

Recognizing the need to strengthen program planning and evaluation, the Central Government and several of the states have discussed with USAID and the project design team plans to carry out baseline surveys and to institute a management information system to monitor the program. The need for periodic evaluations to assess the program's impact on fertility, mortality and morbidity was also discussed. The roposed project includes provision for these activities.

Supervision

Supervisory relationships among workers in the rural health system vary from the formally defined relationships established for workers in the formal health structure (e.g. PHC staff, ANMs and MPWs) to the looser relationships that exist between the CHVs and other health workers.

Direction for ANMs and MPWs comes from the PHC staff (Lady Health Visitors and Health Assistants). They generally look to the PHC for guidance and referral of difficult cases. Since the CHV's are not considered part of the formal health structure, they do not formally receive supervision from other health workers. Informal supervisory relationships do exist, however. The CHVs are generally in close contact with MPWs and ANMs. They frequently accompany them when the ANMs and MPWs visit their villages, and help them with tasks such as rounding up children for immunization, malaria work, recording births and deaths and referring some family planning acceptors. The PHCs are also in a potentially strong position to supervise the CHVs. PHC doctors, according to the Government's plan, are supposed to hold monthly meetings with CHVs to discuss the CHVs' problems and give them advice. Although this does not yet seem to be occurring systematically, CHVs do routinely refer difficult cases to the PHC doctor. They are in reasonably frequent contact with him through their monthly visits to PHCs to collect their pay and supplies, and to bring in sterilization acceptors they have motivated.

Supervisory relationships between CHVs and the village panchayats do not exist to the extent originally anticipated by the scheme. This reflects local community lack of understanding of the importance of preventive aspects of health as well as absence of active participation by the village panchayats in assuming responsibility for health services. These points are discussed more fully in the Social Analysis Section above.

Relationships between supervisors and subordinates appear to be generally positive and supportive. Contacts are fairly regular and vary in frequency from about once a month to once

or twice per week. Supervision appears to be most effective for programs that both supervisors and workers understand well -- e.g. malaria and immunizations. It is weakest in other areas, such as maternal and child health and treatment of malnutrition, to which the rural health system in general does not give adequate attention. In these latter areas, supervisors have not established objectives for the workers to fulfill, on which they can base an assessment of the workers' performance and plans for retraining.

Overall, it appears that supervisory relationships are well established and functioning smoothly. While a number of areas, such as objective setting and performance assessment, need improvement, the supervisory system is not a major constraint to expanding and strengthening the rural health and family welfare system.

Logistics

Logistical problems exist, but seem to be within manageable proportions. Subcenters and PHCs by and large have a limited range of equipment and medicines. Most states budget approximately Rs. 2,000 annually for medicines and equipment per subcenter, and Rs. 8,000 per PHC. It is widely recognized that this is not sufficient to meet demands, but it is also recognized that the demand for expendable medical supplies can be virtually limitless.

Most ANMs, MPWs and CHVs obtain supplies every month when they go to the PHC to receive their stipend or salary. If they run out of supplies between paydays, they usually can obtain additional medicines from their supervisors. The comprehensive NIHFW evaluation of the CHV scheme notes that some logistics problems do exist. In their survey, 60% of CHVs had not received training manuals, 33% had not received the CHV kits, and 41% stated that re-supplies came erratically. The limited field observations of the USAID teams, however, did not indicate quite as serious a problem in the five states as was detected by the NIHFW study.

As may be expected, lack of transportation is also a problem. Most vehicles (assigned exclusively to the MO at the PHC) are UNICEF jeeps supplied in the mid-sixties. Their downtime is considerable. Thus outreach programs must be curtailed especially to isolated areas -- and the frequency of supervision diminished.

Training

The basic system for training rural health and family planning workers in the five states is well established. Most of the workers have already been trained and are in place in the PHCs, subcenters and villages. This is especially noteworthy in the case of the new CHV program: a large number of CHVs have been trained in the past two years. ANM training facilities are generally adequate for the current ratio of one ANM per 10,000 population; more facilities and trainers may be required to increase the number of ANMs to 1:5,000 population, however (and 1:3000 in hilly and remote areas).

The decentralization of much of the health training enables the system to train large numbers of workers relatively quickly. For example, CHV training is conducted by PHC staff (mainly the doctors) at PHCs, which are located in every development block. This decentralized system could also potentially help to make training appropriate to the specific needs of particular areas. Decentralization may lower the quality of training, however. The recent NIHFW evaluation of the CHV scheme notes that, in most states, approximately 40 percent of the PHC staff providing training to CHVs had not been trained to conduct the course. An additional problem is that training materials -- including the basic CHV manual -- are frequently unavailable.

The Government of India's intention in training rural health workers, especially CHVs and ANMs, is to provide basic, practical skills that will enable the workers to meet health care and family welfare needs in the communities. Training curricula and methods do not yet fully support this objective, however.

The curricula appear to have heavy traditional academic orientation. Teaching is mostly through lectures; only a small proportion of time is spent in supervised practical field work. Training may also be limited in scope. For example, ANM training focuses on antenatal, delivery and postnatal care. Treatment of common childhood illnesses, such as respiratory infections and diarrhea, apparently receives little attention.

Refresher training is not yet established for health workers. The PHC doctor apparently holds principal responsibility for retraining, which is supposed to take place during monthly meetings with each category of worker. Little retraining actually occurs, however. For example, the NIHFW evaluation of CHVs found that only 6.3% of the CHVs had received any retraining. It should be pointed out that it is difficult to establish a retraining system since PHC staff and workers at higher levels of the system lack basic information on the most important health problems in their areas, what specific problems each category of worker should address, and how well the workers are performing these tasks.

Overall however, a promising beginning has been made in recruiting and training workers in sufficient numbers to establish the basic structure of the rural health system. The Central and State Governments recognize the weaknesses in the training system and their impact on effective delivery of health and family planning services. They are anxious to strengthen training and retraining, and have discussed several suggestions for improvements with the USAID Mission and the project design team.

Subcenter Construction

A major component of this project is likely to be assistance for construction of subcenters. The Government views the upgrading of the ANMs' rented one-room offices to full-scale first-line facilities for organized public health and medical care as an important element of the rural health system. These facilities are important in providing adequate offices in which care can occur. The rented rooms which currently serve as subcenters in many areas lack any organization or space for care of acceptable

quality; it is difficult for an ANM to examine a woman or child in the sort of dark small space that is usually available in rented facilities. They lack adequate shelving, exam tables and desks. Such an environment discourages utilization by the population.

Under the model scheme, a male multipurpose worker will also work at the subcenter. At least two rooms will be required for these two workers to function effectively, particularly if female patients are to come. More adequate space must become available.

The building program for subcenters is predicated on the future services to be given. The problems of diarrhea care, respiratory care, and malnutrition care at the subcenter level will be addressed in this project. The project will deal with problems of poor utilization by young children and anticipates that many children will come to subcenters in the future. Space in subcenters must be available for the children to be examined, weighed, and treated for selected conditions. The subcenter is only the beginning of an organized plan to extend services closer to the villages. In conjunction with village-level workers, the PHC, and the rural hospital, it forms part of the basic framework of the rural health care system.

During visits to Gujarat, Maharashtra and Haryana, the USAID teams considered engineering and construction aspects of PHCs and subcenters. Attention was centered on the functional aspects and quality of work; plans and design; current construction and contracting practices and procedures; and related problems.

The teams found that PHCs are housed either in very old buildings, built in the 1930s, or in buildings completed in the 1970s. Most subcenters are in small rooms which in most cases are rented or provided by the village panchayat.

The construction quality of existing buildings was generally poor. Existing systems for carrying out and supervising construction activities need to be modified to ensure work of good quality.

Standard designs should also be developed for PHCs and subcenters, with attention to their functional needs and possible requirements for expansion. The use of locally available materials and labor to save costs must be explored.

Another issue is maintenance. Officials at the district level reported, when asked, that funds for maintenance are often insufficient, and may not be provided at all. Since maintenance of the buildings is important not only for upkeep and aesthetic value, but also to reduce bacterial infection, provision should be made for continued maintenance of any new construction.

Specifications and general conditions for contracting are standard throughout India for construction carried out by the State Public Works Departments (PWDs). Each state and district has its own PWD schedule of rates, revised annually, for working out item rates as well as cost estimates for the buildings. Rates appear to be to some extent unrealistic, however, since they do not take into account the remoteness of the areas where some subcenters are to be constructed, nor the small volume and hence small value of work involved. Adjustments will be necessary to attract responsible contractors to undertake the work.

These concerns over the problems of construction and maintenance were raised in discussions with district, state and Central officials. There was general agreement that existing practices are inadequate and that a new approach is needed. One possibility is to form special construction cells, at the district or state level, to look into the problems and take corrective measures.

During the course of the project design, the Mission will work with the Center and states to develop an approach providing sufficient assurances that the construction under the AID project will be carried out adequately and efficiently, and that provision for maintenance is built into the system.

Feasibility and Potential

The Government of India's rural health system is fundamentally sound overall. The system is well established and reaches down to the village level. Large number of workers have been trained and are providing limited services that meet some important health care and family planning needs. Officials and workers at nearly every level of the system, from Central and State Governments to village panchayats, understand the importance of making basic health and family planning services accessible to communities.

As the preceding analysis suggests, the system still needs improvement in several areas. Among the most important of these are planning, evaluation and training. Since problems in these areas affect the system's capability to meet critical health and family planning needs, AID's assistance to the rural health system should include, in addition to construction, provision for strengthening these basic elements.

The prospects for such improvements are good. The Central and State Governments have discussed with the Mission their concern about existing problems, and their interest in undertaking activities to address them -- e.g. baseline surveys, establishment of a management information system, operations research to develop effective ways of training workers and delivering services, and demonstration projects in small areas to test the usefulness of the innovations developed. The Mission concludes that these activities are likely to strengthen the basic rural health system sufficiently to enable it to provide effective health and family planning services, and thus to achieve the project's goal of reducing fertility, mortality and morbidity.

Annex 2

FAMILY WELFARE PROGRAMME

A Statement of Policy

MINISTRY OF HEALTH AND FAMILY WELFARE
GOVERNMENT OF INDIA
NEW DELHI

June 29, 1977

The President in his address to Parliament on March 28, 1977, stated that "Family planning will be pursued vigorously as a wholly voluntary programme and as an integral part of a comprehensive policy covering education, health, maternity and child care, family welfare, women's rights and nutrition". The Prime Minister has on a number of occasions underlined the vital importance of family planning as a means of individual and national development and well-being. This Government is totally committed to the Family Welfare Programme and will spare no efforts to motivate the people to accept it voluntarily in their own interest and in the interest of their children as well as in the larger interest of the nation.

2. Family planning has, however, to be lifted from its old and narrow concept and given its proper place in the overall philosophy of welfare. It must embrace all aspects of family welfare, particularly those which are designed to protect and promote the health of mothers and children. It must become a part of the total concept of positive health. At the same time, it must find meaningful integration with other welfare programmes, viz., nutrition, food, clothing, shelter, availability of safe drinking water, education, employment and women's welfare. It will be our endeavour to bring about this integration in a greater degree. We expect the States to do the same.

3. The change in the name of the programme from family planning to family welfare is a reflection of the Government's anxiety to promote, through it, the total welfare of the family and the community. It is our intention to take the programme forward in the real sense as an investment in man. We wish to make it abundantly clear that in this task there is no room for compulsion, coercion or pressures of any sort. Compulsion in the area of family welfare must be ruled out for all times to come. Our approach is educational and wholly voluntary. There will, however, be no slackening of our efforts in this direction.

4. The Government attaches the highest importance to the dignity of the citizen and to his right to determine the size of his family. We have no doubt that by and large the people of India are conscious of the importance of responsible parenthood; given the necessary information and adequate services, they will accept the small family norm. We will promote all methods with equal emphasis and it will be left to every family to decide what method of contraception it will like to adopt. Employees of the Union Government, State Governments, autonomous bodies, local bodies, etc., will be expected to set an example and to adopt the small family norm.

5. We are totally against any legislation for compulsory sterilisation either at the Central level or by the States. Sterilisation, both male and female, is a terminal method and suitable for those couples who have reached the optimum family size. Services for sterilisation will be offered free of cost to those who voluntarily wish to adopt this method. Similarly other services under the programme will be available to the people free of charge. The acceptance of voluntory sterilisation and IUD involves to and fro travel to a clinic, a brief stay in the hospital, resulting in possible loss of wages which the majority of our people cannot easily afford. In view of this, it has been decided to retain the provision for monetary compensation. Any medical complication resulting from a voluntary sterilisation operation will be attended to free of cost; and if in an unfortunate case recanalisation becomes necessary, this facility will also be offered to the individual concerned under the best possible professional care without any charge.

6. Nearly 80 per cent of our population lives in villages. Medical services are not able to reach them in an effective way. An integrated rural health scheme is on the anvil and will be implemented shortly. It is of the utmost importance that adequate ante-natal, natal and post-natal care is made available to pregnant mothers. To this end a comprehensive scheme of training of indigenous midwives (dais) will be implemented. Under it maternity services will be made available to all mothers who may need them. The programme of immunising children against common diseases such as a whooping cough, diphtheria and tetanus will be expanded further. We expect that the State Governments will give necessary co-operation and assistance in this direction.

7. The direct correlation between illiteracy and fertility and between infant/maternal mortality and the age at marriage is well established by demographic studies. While on the one hand the Government will pursue its policy of according high priority to the improvement of women's educational level, both through formal and non-formal channels, it will also bring legislation for raising the minimum age of marriage for girls to 18 and for boys to 21.

8. In a federal system, the sharing of Central resources with the States is a matter of considerable importance. In all cases where population is a factor as in the allocation of Central assistance to State plans, devolution of taxes and duties and grants-in-aid, the population figures of 1971 will continue to be followed till the year 2001. Family Planning and population control is a subject in the Concurrent List, yet the implementation of the Family Welfare Programme is very much the responsibility of State Governments. Assistance for the implementation of the Programme is provided by the Central Government to the States on cent-per-cent basis. In order to ensure a purposeful implementation of the Family Welfare Programme, the principle of linking 8 per cent of Central Assistance to the State Plans with their performance and success in Family Welfare Programme will be continued.

9. Population education has so far not received the attention it deserves. The NCERT have developed some models for the introduction of population education in the school education system. These models have already been adopted by the Central Schools Organisation. We would urge that the departments of education in the States should adopt these models, or their modified versions, in the syllabus in the schools. Forty-two per cent of our population is below the age of 15 years. It is this population which will soon be entering in the area of matrimony. We must take steps without any further delay to see that the youth receive population education as part of their normal courses of study.

10. The population of India has been increasing at the rate of about one million every month. It has increased by nearly 270 million since 1947 and is today estimated to be 615 million. If the present rate of growth continues, we will be touching the one-billion mark by the end of the century. This rate has to be arrested. The birth rate targets of 30 and 25 per thousand by the end of the Fifth and Sixth Plans respectively can be achieved only with the total and willing participation of the community in the family welfare programme. For this purpose it is important that all media of publicity, including motivation through the extension approach, should be utilised fully by the Central and the State Governments. We would very much expect that just as at the Centre we have involved all media units of the Ministry of Information and Broadcasting in the motivational campaigns, in the States also the State Departments of Public Relations and other departments having their own publicity set-ups would be totally associated with the motivational effort.

11. It is of equal importance that trade unions, chambers of commerce, cooperative societies, organisations of women, federations of teachers, village panchayats and all other institutions which can influence public opinion should be associated intimately with the educational campaigns. The village panchayats can play a significant role in this task. Their potential as change-agents needs to receive greater recognition and attention.

12. No programme will succeed unless voluntary organisations particularly youth and women's organisations participate in its implementation fully and extensively. So far this participation has been very limited. The Government wishes to invite the suggestions of voluntary organisations and such public bodies as are engaged in the general task of Family Welfare for evolving suitable patterns of co-operation and assistance. Full rebate will be allowed in the income-tax assessment for amounts given as donations for Family Welfare purposes to Government, local bodies, or any registered voluntary organisation approved for this purpose by the Union Ministry of Health.

13. While the existing methods of contraception will continue to be available to the people, it is important that the search for newer methods should be intensified. The Government will give special attention to the necessary research inputs in the field of reproductive biology and contraception.

14. The programme and the approach for implementation of the Family Welfare Programme as outlined in the above paragraphs will succeed only if there is willing co-operation from all in full measure. The Family Welare Programme embraces all the principal areas of human welfare. It will be wrong to leave it only to the Ministry of Health and Family Welfare in the Centre and their counterparts in the States. It is essential that all Ministries and Departments of the Government of India as well as of the States give due importance to this Programme and work for its furtherance. The performance of Family Welfare in the States will be intensively and carefully monitored and the Union Cabinet will review the situation in depth at least once a year. Suitable machinery for ensuring coordination with other connected programmes of welfare may be set up in the States also.

Annex 3

DRAFT

National Health Policy

1979

GOVERNMENT OF INDIA

MINISTRY OF HEALTH & FAMILY WELFARE

NEW DELHI

DRAFT

NATIONAL HEALTH POLICY

PREAMBLE

1.1. Health is a positive attribute of life. It is characterised by a state of complete physical, mental and social well-being and not merely the absence of disease. Maximally attainable and acceptable levels of health for all people is our goal. Every citizen should be enabled to attain a level of health necessary to develop his mental and physical faculties to their full genetic potential. Health cannot be viewed in isolation from the overall goals and policies of national development. Development implies progressive improvement in the living conditions and quality of life enjoyed by the society and shared by its members and the central focus of such development is 'man'. Thus, health is both an important pathway to development as well as a desirable end-product of development.

1.2. Any re-organisation of the health services should be in response to the needs of the situation. Improvement in the health status of the population is achievable if there is a shift from the current emphasis on hospital-based, disease-oriented approach, depending heavily on sophisticated technology, to an approach where the attitudes, skills and methods of the trained personnel are in tune with the needs and aspirations of the common man and where the facilities available are equitably accessible to the population in physical, social, cultural and financial terms. The adoption of modern methods of medicine without adaptation to our cultural ethos has only brought in dependency and weakened the community's capacity to cope with its own problems. A wise use of the manifest and latent resources of the community can play a key role in supporting organised health services. A community achieves the highest level of health when it reaches a stage of least dependence on professional intervention and maximum reliance on its own resources and action.

1.3. Growth of medical technology has equipped man with increased ability to cure and decreased sensitivity to 'care'. This has created distortions in medical treatment and has led to ineffectiveness of the health system. If we can make the concept of 'care' a social reality, it would ensure the total health of the individuals as well as of the community.

PRIMARY HEALTH CARE

2.1. Active involvement of people in the health system is a sine qua non for attaining the goal of 'Health For All'. At the International Conference on Primary Health Care held at Alma Ata in September 1978, the Nations of the world have given unto themselves the objective of attaining an acceptable level of health for all the people of the world by the year 2000. As a signatory to the Alma Ata Declaration and in a spirit of service to our own people, we have to take active steps through Primary Health Care to attain this objective.

2.2. Primary Health Care is a practical approach in making essential care universally accessible to individuals and families in the community in an acceptable and affordable manner and with their full participation. Decentralisation and self-reliance are the corner-stones of this approach. The goals of Primary Health Care are attained by social means such as acceptance of increasingly greater responsibility for health by communities and individuals and their active participation in attaining it. This approach involves large scale transfer of simple skills and knowledge to people selected by the community, having their confidence and willing to serve it out of a feeling of compassion and spirit of service. The translation of much of medical and health knowledge into practical action involves use of simple and inexpensive inventions which can be readily implemented by ordinary people with minimal training leading to the greatest benefit to the society.

2.3. Primary Health Care can only succeed if the organised health services provide full logistic and professional support to the voluntary workers residing within the community. Such a system would result in optimal utilisation of the knowledge and expertise at higher levels and in the long run, it can be expected to relieve the overburdened curative services in the urban and semi-urban areas. The development of an effective primary health care system both for rural and urban areas would ensure the following:-

(i) A greater awareness among the community and population of the health problems and ways to tackle them at their own levels;

(ii) Intervention at the lowest practicable levels by a worker more suitably trained;

(iii) Optimal utilisation of knowledge and expertise by higher level technical experts, be they health workers, physicians or specialists;

(iv) Increasingly less dependence on hospitals and thus optimal utilisation of such facilities for cases where they are actually needed.

PREVENTIVE AND PUBLIC HEALTH SERVICES

3.1. The emphasis on public health services has slowly decreased in the last 30 years, yielding its own rightful place to curative services. The trend has to be arrested and reversed. The coverage of public health services and provision of preventive services are now spatially very limited. Municipal and local authorities responsible for such services generally suffer from a lack of will and resources to implement them effectively. It is rational and economical to deal with a cluster of causes for poor health conditions on a broad front in the form of integrated package of services which are more than a mere collection of health interventions. There is,therefore, an urgent need to set up a chain of sanitary-cum-epidemiological stations throughout the length and breadth of the country, manned by suitably trained and equipped staff. Such stations can conveniently take care of environmental health problems, detection and control of epidemics, handle checks on quality of food, water, etc. Investments on such stations now will have a relatively high pay-off in the long run.

3.2. The pattern of diseases in developed countries has changed radically in the last 50 years. The range of vaccines, sera, etc.,is ever increasing. Our aim on the preventive front should be to achieve 100% coverage of the total population by the year 2000 in terms of inoculation, vaccination, etc. The wherewithal is within our technical competence.

WATER SUPPLY AND SANITATION

3.3. Provision of safe water supply to the population and improvement in sanitation is basic for improving the health status of the people. This needs to be done at a cost and with a technology which the nation can afford. We should, therefore, aim at providing safe drinking water and improved sanitation to all population within a given time-frame.

PROMOTIVE SERVICES

4. For a meaningful involvement of the community in the health care system, education about the advantages both immediate and long-term are necessary. It is,therefore,in the interest of the health system itself to take on the responsibility for explaining, advising and providing clear information about the favourable and adverse consequences of interventions available or proposed as well as their relative cost. As part of promotional services, it would be necessary to educate people about food habits, nutrition, breast-feeding, etc.,which are themselves not costly if properly adopted and which could lead to substantial savings in terms of human misery. In view of the large-scale widely prevalent malnutrition, the question of proper nutrition assumes special importance and requires concerted action. There would also be a difficult but pressing need to overcome religious and social taboos which often-times prevent people from adopting healthy habits.

FAMILY WELFARE AND POPULATION POLICY

5. A reduction in birth rate is part of the National Family Welfare Policy, a Statement on which was adopted in June 1977. Health and family welfare are so intimately intertwined that, without an active and vigorous implementation of the Family Welfare Policy, the National Policy on Health or, for that matter, any policy of national development, cannot even be conceived of.

MATERNAL AND CHILD HEALTH SERVICES

6.1. The future of any nation is the future of its children. If the limited resources in the health sector are to be preferentially applied to any segment of population, it should logically flow to children and mothers. Infant mortality, child mortality and maternal mortality in this country are stark figures signifying our inability to achieve a break-through in this field. Bold attempts need to be made to ensure 100% health coverage in the next 10 to 15 years for all children in the age group 0-5 and by the year 2000 of all children up to the age of 15.

6.2. Maternal services are sparsely distributed. Our dependence on professional birth attendants will continue for a long time. While there may be an addition in the institutional facilities for deliveries - particularly to provide for complicated cases - we should ensure that all deliveries are handled by competently trained persons. This would reduce significantly the maternal mortality and morbidity.

6.3. Along with vigorous steps needed to achieve reduction in the birth rate, we need to improve the facilities available to mothers and children to assure the families of the safety of their progeny. This, by itself, will have a psychological impact and would over the period favour a reduction in the birth rate.

CURATIVE SERVICES AND HOSPITALS

7.1. We have inherited a system of health services and medical education from the colonial days which has a large emphasis on treatment in hospitals and cure of diseases. With increasing sophistication, we are now devoting 80% financial and manpower resources in the health sector to this segment of health services which is more or less concentrated in urban areas. With the public sector, private sector and voluntary sector operating jointly and sometimes at cross-purposes, there is avoidable disorganisation in the provision of curative services. Even the general hospitals run by Government do not provide equality of access to the poor. There is often-times duplicate and triplicate utilisation of facilities in an effort to get second and third medical opinions. A method should be developed to avoid this wastage of scarce resources. The urge of

the common man to get quick and effective medical treatment, particularly when he is at the physical and psychological nadir is understandable. The pace of investment in hospitals and curative services has to be slowed down, linking it rationally to a national policy on urbanisation. One can, however, hope that extensive provision of preventive, promotive, public health services would go a long way to relieve the burden of curative health system to a large extent.

7.2. Even so, there would be a need to provide an increasing number of hospital beds: firstly to take care of some of the under-served, semi-urban and rural population and secondly, as part of the referral system. Construction of hospitals on traditional methods is a costly proposition, most of the money going into brick, mortar and equipment. We need to explore ideas on new type of hospitals in which modern construction is restricted only to essential areas such as theatres, wards, etc.; the rest being of simple structures using local materials with provision for members of the family to stay and provide basic nursing services.

7.3. We have, in addition to the modern system of medicine, indigenous systems like ayurveda, unani, siddha, naturopathy and homoeopathy in wide use. There has so far been no coordination among all these systems, either in terms of education or in terms of service, not to speak of integration. We should now begin an attempt on a co-ordination of the services offere by all these systems so as to obtain optimal economic utilisation.

7.4. The trend is towards increased application of sophisticated modern technology, be it auto-analysers, linear accelerators, EMI scanners or intensive care equipment and the like. Very often these provide a cultural shock for the average Indian. In any case, they tend to increase competition amongst professionals to acquire more of these sophisticated techniques at great cost and thereby increase the distance between the patient and the doctor. We must learn to use increasingly appropriate health technology replicable with scientific, technical and managerial resources available within the country.

MEDICAL EDUCATION AND HEALTH MANPOWER

8.1. Medical education has suffered as a result of cultural dichotomy coupled with parallel development. The modern medical system has kept pace with developments in the rest of the world but the type of education imparted particularly at the under-graduate level is heavily hospital-oriented with little relevance to Indian situations. This makes a fresh graduate unsuitable to handle situations in the community and unable to appreciate the problems and dilemmas of the community. The indigenous (traditional) systems of medicine have, after years of neglect, started coming into their own. The earlier attempts to integrate the modern medicine with the traditional systems have failed. While no attempt to forcibly integrate any system of medicine should be made, all the systems

should realise, in the Indian conditions, the limits and potentials of other systems and draw inspiration from them and should support each other mutually. This can be done only by a concern for other systems and understanding of their functioning.

8.2. The training of agents of health care in sufficient numbers at appropriate levels, with right attitudes, outlooks and functioning in an orchaestrated manner, holds the key to success of any health system. The hierarchical structure of the present day health manpower and the roles allocated to each level in the hierarchy are the outcome of a historical process. A dynamic process of change and innovation is needed. The concept of health team is important in this context. The national medical education policy aims at qualitative and quantitative development of adequately trained health personnel of all categories in a reorganised structure keeping in view the training of a composite health team. To help in innovative development of medical educational processes and ensure a continuous input of properly trained manpower, it would be necessary to set up a Medical and Health Education Commission embracing all systems of medicine and all categories of medical and para-medical personnel.

HEALTH PLANNING AND HEALTH INFORMATION SYSTEM

9. The need for an effective information system in the Health field at all levels providing for collection, processing, storage and retrieval as a tool actively aiding appropriate decision-making and programme planning in the field of Health is well recognised. We have to gear our efforts to set up a dynamic information system to support the Health Planning and decision-making machinery.

MENTAL HEALTH

10. Mental well-being is an essential component of the state of good health. With increasing industrialisation and greater strains in the community, mental health problems are on the increase. Here again, a primary health care approach would enable isolation of the problem at an early stage and handling of the same in an appropriate manner. Traditional Indian practices such as yoga, sadhana, etc., need to be strengthened and made universally available to attempt non-medical methods of handling mental health problems.

REHABILITATION

11. Rehabilitation forms the fourth side of the health square, the other sides being prevention, promotion and cure. Medical rehabilitation services are

not fully available to those in need of the same. Here again appropriate technology should be increasingly used. Medical rehabilitation also needs to be coupled with social rehabilitation in certain circumstances like 'burnt out leprosy cases', etc.

BIO-MEDICAL ENGINEERING

12. Developments in this field are occurring every day and at a rapid pace. However, particularly due to miniaturisation occurring in electronics, it should be possible to take advantage of the electronic industry in the country to make available such advances to a multitude of institutions. This branch of medical science has so far not been adequately attended to. The industrial capability of this country is of a high order and it should be possible, with some attention, to keep pace with developments in this field and transfer them in an appropriate manner to Indian conditions.

PHARMACEUTICALS

13.1 It would not be far wrong to say that the pharmaceuticals industry dominates the health sector and the doctors are deeply influenced by the drug industry. Instead of being able to dictate to the drug industry, the medical profession is in fact dependent on the drug industry for whatever continuing education it receives in the form of literature. Over-utilisation of drugs so as to increase the profits of the drug industry, has become the end and hospital and the medical profession are used as a means towards this end. This problem has been deliberated upon by various committees, essentially to ensure that the drug industry plays a subordinate and not a dominant role, without, however, minimising the plenitude of good that it brings to millions of people. The medical profession should have a greater say in determining the direction of growth of the drug industry.

13.2. Reliance on synthetic chemicals and antibiotics is a growing worldwide phenomenon. Greater utilisation of drugs tends to increase the cost of the health system. On the other hand, vaccines and sera which are used in preventive medicine need to be encouraged and new vaccines need to be developed.

13.3. In so far as the medicines belonging to the traditional systems are concerned, the age-old practices of local preparation of such drugs have slowly vanished leading to greater commercial preparation of such durgs. It might be worthwhile and necessary to encourage local manufacture of such drugs in small communities wherever such treatments are in vogue. Further use of herbs and medicinal plants, particularly for common ailments wherever practicable, needs to be encouraged. It is expected that the local growing of such herbs and plants, harvesting, storing and preparation of medicines out of them, at the community level, would go a long way towards self-reliance.

13.4. In keeping with the concept of community participation and self-reliance it is also necessary to reduce dependence of the population on the formalised medical system for the use of medicines. While on the one hand it would be necessary to guide the population in the use of medicines particularly those which toxic or have reactions, it is also necessary to depend on the people themselves for knowledge of their own conditions and use of appropriate remedies. Thus, consistent with our concern for overuse of drugs and professional supervision on the use of drugs having toxic or side-effects, we should liberalise the idea of self-medication. This will imply strict control on the quality of medicines available in the market.

RESEARCH

14. No nation can afford to neglect the support of fundamental and basic research, for without it there can be no proper teaching of science and no national capability for solving unresolved problems, meeting changing situations and for adopting, in certain instances, known technology to suit local conditions. And yet, highest priority should be given to applied research, in particular health services research, if the technological achievements of medicine are to be placed within the reach of those who need them most. Health services research is holistic, multi-disciplinary in character involving the joint participation of bio-medical sciences and social sciences. Such research should be carried out within the health service system and research priorities determined as a result of joint discussion between researchers, administrative decision-makers and the public. The whole ethos of such research should be based on discovery of simple, low cost, appropriate health technology, the results of which are replicable under routinised settings. We also need to devote ourselves to basic research, particularly with a view to developing solutions to problems plaguing our country. We are yet to develop effective cures or vaccines, for such diseases as malaria, leprosy, etc. Likewise, there is immense scope for research in matters relating to Human Reproduction. Research in the field of medicine should be relevant to the needs of the community.

LEGISLATION, INSURANCE AND COORDINATION

15. Health being a State subject, the approaches to legislation in the health field would necessarily vary from State to State. A variety of legislation is already on the statute book, be it on the national level or State level. It would be necessary to review these items of legislation and work towards a single comprehensive legislation applicable to the health field. The services provided by government are generally free. This leads to a situation where there is not enough appreciation that the services do cost money to the nation and, therefore, should be utilised only where it is essential and unavoidable. A realisation of the utility of such services can be brought about by educating people as also by levying nominal charges for all services. The possibility of

introducing some form of national health insurance, at least in the future, to provide for guaranteed health services to all segments of population needs to be pursued. In the present system since there is a co-existence of the private sector, voluntary sector as also the public sector, it is essential to coordinate the services by these sectors. The possibility of setting up coordination committees to regulate the services available in each of these sectors needs to be explored. Secondly, in the private sector and to a limited extent in the voluntary sector, sometimes the fees charged are rather high. While this drawback will continue as long as the private sector exists, an attempt needs to be made to ascertain whether there can be any self-regulation. As part of this exercise bold attempts need to be made to end the system of private practice by doctors in Government service and in Medical Colleges.

INPUTS IN HEALTH-RELATED FIELDS

16. Developments in health come not merely as a result of inputs and activities in the health field, but also due to developments in health related fields such as agriculture, water supply and drainage, communication, etc. At the community level, all health activities must be coordinated with and in fact, form part of, total rural development. To the extent decentralisation of resources, planning and implementation can be achieved, there will be greater efforts and development in all fields and thus in health also. Such decentralisation should, therefore, be actively pursued and supported. Even at State and national levels, health activities and inputs should benefit from investments in health-related fields and to that extent, coordination with other sectors of development have to be voluntarily sought for and achieved.

CONCLUSION

17. The following should, therefore, be the short-term and long-term goals of the national health policy:-

17.1. Short-term goals

(i) to eradicate /control communicable diseases in the country;

(ii) to provide adequate infrastructure for primary health care in the rural areas and in urban slums;

(iii) to utilise all available methods for health education and spread the message of Health and Family Welfare;

(iv) to utilise knowledge from different systems of medicine for providing quick and safe relief from sickness and debility at the cheapest possible cost;

(v) to reorient medical education to be in tune with the needs of the community;

(vi) to provide increasing maternal and child health coverage.

17.2. Long-term goals

(i) to improve public health services by setting up a chain of sanitary-cum-epidemiological stations;

(ii) to ensure 100% coverage of all segments of population with preventive services;

(iii) to create a self-sustaining system of health security so that earnings of the individual are not affected adversely during periods of illness;

(iv) to impart medical education in a medium which is an integral part of our culture and life-style and thus remove the foreign concepts associated with foreign languages which are major factors inhibiting people from understanding the true and proper role which medicine plays in the development of a healthy community;

(v) to utilise available knowledge from the ancient and modern systems of medicine in an effort to develop a composite system of medicine, thus obliterating the caste system prevailing in the field of medicine;

(vi) to inculcate a sense of self-reliance and discipline in all segments of population so that all four sides of the health square, namely, prevention, promotion, cure and rehabilitation are effectively handled at the local level consistent with the developments in the field of medicine.

Annex 6

APRIL, 1979

Government of India Ministry of Health & Family Welfare

REVISED

MODEL PLAN FOR CREATION OF FACILITIES AND PROVISION OF SERVICES UNDER AREA PROGRAMME

.....

1. Staff Sub-P.H.C Level

1.1 All districts chosen under this scheme would be converted into Multipurpose Workers districts in the next available instalments, if not already so converted, and training of M.P.W.s, and positioning of M.P.W.s @ one male and female worker per 5000 population will be completed by 31st Oct.'82. This figure of 1:5000 will relate to estimated mid-1982 rural population.

1.2 Selection of villages for location of sub-centers @ 1 per 5000 population will be started rightaway.

1.3 ANMs will be posted to the selected districts on a priority basis to fulfill the above objectives.

1.4 Community Health Volunteer training scheme in all selected districts will be completed and CHVs positioned in all the villages by 31st October, 1982 at the latest.

1.5 Dais or traditional birth attendants or Indigenous maternity attendants will be trained in all the villages by 31st October, 1982.

2. Facilities and Equipment to be provided

2.1 All M.P.W.s (male and female ANMs) CHVs and trained dais will be provided with proper kits.

2.2 M.P.W.s and CHVs will also be provided with proper work manuals, which will also function as reference books.

2.3 A lump-sum amount of about Rs.2500/- per annum will be provided to each PHC as cost of raw materials to hold nutrition demonstration sessions.

2.4 Under the MPW scheme, there would be a supervisor, male and female for every 4 Sub-centers.

2.5 Provision of additional sub-centers.

At present, a sub-center caters to a population of about 10,000 and on an average 8-10 sub-centers are attached to each PHC. These sub-centers are manned by an ANM assisted by a part-time female attendant.

The ANM is supposed to provide ante-natal and post-natal care, conduct deliveries, provide nutritional education, look after infants, undertake immunisation programme, motivate cases for family planning methods, follow-up acceptors of family planning methods and carry on health educational programmes. The Government of India have accepted in principle to provide an ANM for 5,000 rural population. However, on account of financial constraints and non-availability of trained manpower, it has not been possible to reach a target of one sub-center/ANM per 5,000 population. The Fifth Five Year Plan provided for the employment of additional ANMs to reach a target of one ANM per 8,000 population by the end of the Plan. Under the Area Project, it is proposed to establish one sub-center/ANM per 5,000 rural population (per 3,000 population in tribal and hilly areas) in the selected districts.

Buildings will be constructed for each sub-center on a general layout as applicable in each State, using locally available and suitable raw materials and according to local costs of PWD (may also include prefabricated structure). Each sub-center building will be located within the inhabited area of the villages chosen for this purpose and the State Government should undertake to provide land measuring at least 5000 Sq. feet free of cost for this purpose. It is preferable that this site be in a central area of the village but in no case should it be outside and away from the inhabited area of the village.

The building will provide accommodation for a consultation room, quarter for the ANM and a courtyard which can function as the open air instructional area.

The building would also be provided electric connection where electricity is available in the village. The State Governments should bear all costs for bringing electricity to a point outside the buildings;

only internal wiring, etc., being chargeable to this Project.

The sub-center site should also be provided with safe potable drinking water through a pump or well, unless in its vicinity a water source already exists in the village.

Where possible and necessary, fencing will also be provided around the sub-center building.

Under the project construction of buildings for all sub-centers already established, but which have no buildings (backlog), plus about 20% of additional sub-centers required for reaching a target of 1 sub-center for every 5,000 population (mid-1982 estimate) will be taken up.

2.6 No building will be provided for the Male MPW, who has to be accommodated in a rented building. He may use the consulting room facilities in the sub-center building when necessary. It is not proposed to accommodate the male MPW in another part of the same sub-center building occupied by the ANM as this is likely to create unavoidable complications in the existing social ethos of rural Indian Society. However, this matter can be settled according to local conditions.

2.7 For every four sub-centers there would be a supervisory Health Assistant (male and female). In a centrally located sub-center, additional accommodation will be created for the female Health Assistant (LHV) only, including in rented buildings.

2.8 Suggested list of equipment/furniture, etc., to be provided at each sub-center is attached at Annexure-I. This is only as a general guideline and may be reviewed by the States according to local requirements.

2.9 All buildings for sub-centers and equipment, etc., in all sub-centers in the selected districts (whether established earlier or after the project starts)will be brought on par with the models mentioned above by supplementing/substituting or strengthening the existing arrangements.

2.10 All buildings for sub-centres and provisions of other facilities will be completed by 31st March, 1983. If construction of additional sub-centres leads to a time lag, the sub-centres would be established and staff posted in rented buildings by the time schedule mentioned at para-1.

3. Staffs Primary Health Centre Level

3.1 All staff prescribed under the MPW/CHV scheme pattern at the PHC level will be positioned by 31st October, 1982.

3.2 In addition, at each PHC, 2 posts of nurse- midwives for help in conduct of operations will be provided (These already exist in many cases in the form of Head-quarter ANMs).

4. Facilities/Equipment at PHC Level

4.1 All buildings for PHCs and attached Rural Family Welfare Centres, complete with staff quarters, etc., would be completed in an integrated manner before 31st March, 1983. Major repairs necessary for improving conditions in existing buildings will also be completed by that date.

4.2 In existing PHCs/RFWC Buildings, where necessary, a room would be strengthened/improved to render it suitable for use as an operation theatre, on the lines mentioned at Annexure II, including provision of O.T. equipment.

4.3 All PHCs will be provided with a standard set of surgical equipment as at Annexure-III. In existing PHCs additional equipment will be provided to bring them on par with the model furnished at Annexure-III. This list is only a general guideline and does not restrict the choice of each State to modify the same according to local requirement.

4.4 Proper instructional material will also be provided at PHC level.

5. Upgraded PHCs/Taluka Level Hospitals :

5.1 A centrally located PHC in a group of every four PHCs covering a population of almost 400,000 will be upgraded. A PHC located in a taluka town or a small urban area will be ideal for this purpose. If however, a taluka level or any other hospital exists for a group of 4 PHCs, then such a hospital could be upgraded.

5.2 The upgraded hospital or PHC will have a minimum of 30 beds (or will be brought up to this level) of which atleast 10 will be reserved or used for Family Welfare Services such as sterilisation, MCH and also MTP. Additional buildings / bed strength as may be required will be created for this purpose. Under the project, however, only additional 10 beds and an Operation Theatre plus some staff strength will be provided. The remaining additional requirements to meet the standards will be added in due course of time. Thus only PHCs identified for future upgrading may be selected for this purpose. (annexure IV).

5.3 In addition to strengthening identified future upgraded PHCs or centrally located taluka level hospital, in some selected taluka/sub-divisional towns, if need exists, a hospital which needs further strengthening (a case has to be made out for this) may be suitably strengthened on the same model as suggested for future upgraded PHCs (i.e. one O.T., 10 beds plus some staff).

5.4 The upgraded PHC or Taluka Level Hospitals will have an additional complement of staff. Additional staff required will be recruited and positioned at an early date if not already provided. (See Annexure V)

5.5 Staff quarters for essential staff as mentioned will also be created.

5.6 The Operation Theatre equipment and additional facilities as may be required at the upgraded PHC/Taluka Level Hospital are suggested at Annexure VI)

5.7 For full utilization of services at upgraded PHCs / sub-divisional hospitals, facilities of common investigation should be made available by the provision of laboratory equipment, chemical reagents and exployment of a laboratory technician.

6. Training and employment of Dais

6.1 Even with the provision of one sub-center for 5,000 population it will not be possible for the ANM to provide adequate coverage to about 150-175 expectant mother in her jurisdiction. Thus, a sizeable proportion of the population will continue to depend on the traditional birth attendants (DAIS) for services. Under the area project, it was proposed to train and employ on a part time basis 2 Dais per sub-center in the selected districts so that they become amenable to the supervision and guidance of the ANM. On an average

about 100 Dais will be trained in each PHC, depending on the number of sub-centres.

6.2 At the district level, it is proposed to provide one Public Health Nurse in the selected districts for supervising and guiding the work of the ANMs and Dais.

6.3 The CHVs are being provided Rs. 50/- a month as Honorarium and Rs. 50/- per month for medicines. The Dais will receive only incentive amount of Rs. 2/- per birth reported.

6.4 It is proposed that in addition

(a) The CHV will act as a depot holder for conventional contraceptives ;

(b) The Dais are provided an honorarium in cash or kind in the selected districts based on performan .

7. Construction Wing:

For the purpose of speedy completion of existing incomplete buildings, strengthening or major repairs to such buildings, or construction of all new buildings before 31st October, 1983, a separate construction wing, with adequate number of construction divisions work norms applicable in each State will be created and will be funded upto 31st March, 1984 only.

8. Nutrition Programme :

It is proposed to include a scheme for the treatment of malnourished children in the Project. The treatment will be organised by following the below mentioned approaches :

a. Hospitalisation;
b. Establishment of Nutrition therapy centres;
c. Domiciliary treatment.

The Nutrition Programme will have the following three objectives :-

a. To provide facilities at the PHCs level for the treatment and rehabilitation of the severely malnourished children and thereby reduce infant mortality.

b. Improve nutrition education facilities through the existing health infrastructure and thereby disseminate knowledge regarding nutrition matters to the members of the community.

c. Integrated nutritional programme along with MCH programme.

Nutrition Rehabilitation centres will be set up in selected areas where the incidence of mal-nutrition is high. The existing staff of the Primary Health Centres will look after the Rehabilitation centres. However, an additional ANM/LHV trained in nutrition will be provided in selected PHCs where the incidence of mal-nutrition is high. The village community through the panchayats will extend support to this programme by providing voluntary labour and food articles. This programme has to be tried out initially on a selective basis in some areas of the project.

9. Communications/Mass Media :

The scheme for extending information, education, and communication support will have the following objectives :-

i. To reach all eligible couples through mass media, group and inter-personal channels.

ii. To focus attention on the family welfare programme as an integral part of welfare services.

iii. To remove doubts and misconceptions regarding the family planning programme.

iv. To provide orientation training through formal and non-formal education to all the opinion leaders.

It is in the field of demand generation for family welfare services and methods of contraception that a big thrust is called for. Based on experience gained so far in this field, there is increasing evidence that the approach in the future has to be through higher level of inter-personal contacts.

At present, in media endeavour, besides national efforts at the Central Government level, there is a media wing at the State level and a media outfit at the district level. The district level consists of a Media Officer and two Deputy Media Officers. At the Block level there is an Extension Educator in each PHC. There are also Family Welfare Health Assistants at 1 for 20,000 population who are being regrouped into MPWs. Besides holding camps, meetings, the workers in this set up also have audiovisual media equipment such as projectors at the district level.

For the new strategy under the area programmes, no model is sought to be prescribed. It will be for each project in different State to try and evolve innovative methods suited to local ethos. The efforts can be different in each district in the same State also. Within reasonable financial outlays, each State may develop suitable models, provided no permanent infrastructure or long-term commitments in regard to the staff or hardware are created.

However, some ideas which have been put forward can be shared here :-

(a) A large number of opinion leaders camps for both males and females should be conducted during which, by carefully orchestrated syllabus, the small family norm, details of various methods available, care of mothers and children, nutrition needs etc., could be disseminated to the influence groups. Creation of a nucleus of people in each village, suitably motivated in this fashion, may lead to radiation of the messages faster in the community. Such people could also be equiped with booklets and supplied with regular magazines, etc., to keep up their interest and to enable them to spread the message more effectively.

(b) The CHVs and trained dais should be encourages to be more active for this purpose.

(c) All forms of rural gatherings, for rural development programmes for mahila samiti activities, youth clubs, etc. could also be used.

(d) Informal but traditional modes of propaganda in the villages could be exploited such as weekly soothsayers, street-corner magicians, acrobats etc.

(e) Any other traditional media outlets, such as cinemas, T.V. etc., could form part of the individual strategy for each area.

(f) All field level functionaries of other departments may also be oriented in this regard.

(g) Support of universities, colleges, schools and the National Adult Education programme will be enlisted for spreading the acceptance of the small family norm.

(h) Additional inputs in the form of A.V. Units, Cassette Tape-recorder, education kits etc. where necessary will be considered.

(i) Besides providing the inputs indicated above, support will be extended for effectively utilising television facilities, if such facilities are already available in the districts to be covered under the Project. Support will also be extended to the Radio Stations for dissemination of knowledge and information regarding the Family Welfare Programme. At the State level funds will be provided for strengthening the Offset Press and the film units.

10. Management Set up and Evaluation :

10.1 For effective coordination and integrated functioning of the project as well as achievement of objectives, it is essential that at the district/divisional/State and Central levels adequate additional machinery are set up for the duration of the project period. This could consist of :-

(a) At the district level, a Project Officer with a component of staff, a project implementation and evaluation committee which will coordinate activities of various wings for creation of infrastructure, positioning of staff, provision of supplies, creation of demand etc. It is essential that all development departments are coordinated and for this purpose it will be useful to have this unit directly under the collector of the district.

(b) At the State or regional level within the State, suitable coordination committies with some office support.

(c) At the Central level, a Central Coordination Committee and a wing to oversee, monitor and evaluate progress as well as provide reports to the donor agencies and keep a watch on budget receipts and disbursements.

10.2 The organisational set-up in each State could be decided upon locally but should be within reasonable financial limits. At the end of the Project period, if it is thought necessary to continue this organisational structure, the State Governments should bear the extra cost for its continuance.

10.3 Management aspects will also include involvement of Population Centres set up under the first IPP as well as consultancy and training assistance from management institutions to be identified for this purpose. Costs in this connection would form part of the cost of the project.

10.4 Management training for all kinds of staff, including updating in technical matters would be an important input. The information and monitoring system could be arrived at by consultation with Population Centres/Management Institutions, by the States.

10.5 In order to ensure continuity of the project, it will be necessary to see that the staff posted in the project areas are not transferred outside the project areas during the project period. For creating additional staff positions in the project areas, the States will also naturally ensure that other areas in the State are not depleted of staff.

10.6 Population Centres/management institutions may be asked to undertake essential base line/bench mark surveys.

11. State Governments Commitments :

11.1 The State concerned should ensure meeting various date lines without fail as indicated against the different items mentioned above.

11.2 It is particularly the responsibility of the State to complete selection of locations for PHCs/sub-centres and upgraded PHCs and to provide adequate land in a central location in the selected village/town for this purpose free of cost and in a speedy manner.

11.3 The State Govt. should undertake to bear all costs relating to the facilities created under the project and continued beyond the project period, either under a centrally sponsored scheme as may be available generally or under its own plan or new plan schemes as the case may be.

11.4 The State should also provide according to a prescribed time schedule, all the periodical or other reports, data, etc. as may be agreed upon under the project.

11.5 Wherever electricity has to be provided for a sub-centre, PHC, upgraded PHC, the State Govt. should ensure

(a) Rural electrification is extended on a priority basis to the village concerned.

(b) A point from which electricity could be drawn into the premises is provided just outside the site at the cost of the State/Electricity Board concerned.

12. Costs

12.1 Cost to be funded for the Project by the External Participating Agencies (Donor/Lending agencies) will be costs additionally incurred over the base level of 1979 but including costs on preparatory steps to be taken in 1979-80.

12.2 Local budgetary procedures for and sharing of this cost will be seperately determined by the Central Govt. in consultation with the State Government concerned.

12.3 It will be highly desirable for each State Govt. to work out a procedure under which all costs under the project could be under one local buaget head irrespective of source of budgetary funds namely - Centre/State.

. . . . . .

Note : GOI and the states agree that no portion of the USAID Grant funds will be used to pay motivation fees for family planning or for abortion related services.

Annexure - I

Suggested list of furniture/equipment supplied to each sub-centre

	Quantity
1. T.W. Examination Table	1
2. T.W. Writing table	1
3. T.W. bug proof chairs	3
4. T.W. Benches	1
5. T.W. twin basin stand	1
6. T.W. Stool	2
7. Side racks	1
8. Medical chest	1
9. Revolving stool	1
10. Wooden screen	1
11. Foot step	1
12. Coat rack	1
13. Stove (Kerosine)	1
14. Sauce pan with lid	1
15. Syringes (2 c.c.)	5
16. Hypodermic needles	3 dozen
17. Dressing bins	2

Note : USAID Grant funds will not be used for the purchase of equipment for abortion.

Suggested Conversion of a Room into operation theatre at the P.H.Cs/R.F.W.Cs

---

An expenditure with a ceiling of Rs.10,000/- can be incurred for converting the existing labour room of the Primary Health Centre into an Operation Theatre provided the existing labour room is already having a pucca construction and RCC Roof. The following items of works would be covered under this assistance.

1. Electrification, repairs, relaying or installation in the labour room.

2. Sanitary fittings for scrubbing and clearing of instruments.

3. Extension of existing water supply arrangements up to labour room (within the building only)

4. Putting up of double doors.

5. Construction or conversion of existing windows into fixed glass windows for proper lighting.

6. Strengthening or repair of floor of the labour room.

7. Tiling of the inside walls of the labour room up to the height of minimum 6 feet.

8. Oil painting of the labour room

9. Installation of exhaust fan

10. Other minor additions and alterations in the existing constructions.

Suggested Equipment for Taluk Hospitals/PHCs(for Tubectomy & MTP)

1.	Dressing drums 12"	4	Nos.
2.	Surgical Gloves 6 1/2, 7 & 7 1/2 sizes	2	dozens.
3.	Mayo's trollies standard size	2	Nos.
4.	Abdominal Wall retractors	3	sets
5.	Surgical Blades	2	dozens
6.	Luer-luck syringes with finger grips	3	Nos.
7.	Hypodermic needles size 20 & 22	12	each
8.	Allis forceps	6	Nos.
9.	Babcocks forceps	4	Nos.
10.	Scissors curved SS 6"	1	-do-
11.	Scissors flat SS 6"	1	-do-
12.	Suture needle cutting 1/2 circle	12	-do-
13.	Suture needle Round body 1/2 circle	12	-do-
14.	Eyeless needles	6	-do-
15.	Straight cutting needle	12	-do-
16.	Needle holders 8" straight	2	-do-
17.	Artery forceps 5" curved	6	-do-
18.	Vaginal speculum	2	-do-
19.	Uterine Sound graded	3	-do-
20.	Ant. Vaginal Wall retractor	2	-do-
21.	Hanlis/Hagor's dilators	1	set
22.	Karman Cannulae 4-12 mm flexible	500	
23.	Uterione Curretee Sharp & Blunt 4, 6, 8 and 10 mm sizes	2	each
24.	Menstrual regulation syringe Chemko (with lubricating oil)	4	Nos.
25.	Shadowless lamp 16" diameter	1	No.
26.	Vacuum/Suction apparatus (Indigenous)	1	No.
27.	Ovum/forceps 3 sizes Hand/Elec. Operated	2	Nos.
28.	Valsellum blunt teeth	3	Nos.
29.	Cheatle forcep	1	No.
30.	Sponge holding forceps	2	Nos.
31.	Instrument Steriliser	1	No.

Note ·1) All Instruments should conform to I. S. I. specifications and be made of stainless steel.

2) USAID Grant funds will not be used for the purchase of equipment for abortion.

Annexure IV

Upgraded PHCs/Taluk Level Hospitals

(Rs. in lakhs)

Additional suggested non-recurring expenditure per unit

1.	Construction of Operation Theatre	0.70
2.	Construction of 10 bedded ward	0.45
3.	Equipment for Operation Theatre (as per list attached)	0.15
4.	Equipment for ward	0.12
5.	Construction of accommodation for essential staff	1.00
6.	Laboratory equipment	0.15
7.	One Vehicle (Ambulance) for preparative work.	0.50

. . . . . .

Note : USAID Grant funds will not be used for the purchase of equipment for abortion.

Additional staff to be provided at upgraded Primary Health Centre/Sub-divisional Hospital for 10 bedded ward and operation theatre.

******

1.	Gynaecologist	1 *
2.	Paediatrician	1
3.	Nursing sister (for operation theatre and ward)	1
4.	Staff Nurses (including 1 for O. T.)	4
5.	Ward Ayas (including 1 for O. T.)	3
6.	Sweeper	1
7.	Laboratory Technician	1

* Will be provided to sub-divisional hospitals having the following facilities :-

1. Have minimum of two medical officers with necessary supporting staff.

ii) Have minimum of 15 beds

iii) Have a nucleus for minor surgical work and facilities for the same.

iv) Is located in a building owned by the Govt. or local body.

v) Has got adequate nursing and other supporting staff.

vi) Has got a family welfare clinic attached to it.

vii) Has a good potential to have about 300 tubectomies, MTP cases from the area served by it.

viii) Has good communication and is easily approachable from the neighbouring PHCs.

ix) Has got adequate land available within the premises for the construction of operation theatre and the ward.

Suggested List of Surgical Equipment for upgraded PHC/Taluka level Hospital

Sl. No.	Name of items
1.	Operation gowns
2.	Caps of headties
3.	Face masks
4.	Slippers
5.	Polythelene Aprons

LINEN FOR SURGERY

1.	Abdominal Sheets
2.	Tetra Towels
3.	Table Covers
4.	Hand Towels
5.	Small tetra Towels for wiping hands
6.	Glove bags)
7.	Sponge Towels) made of Gauge
8.	Skin Towels)
9.	Gauge Than

FOR STERILISATION ROOM

1.	Electric Autoclave
2.	Instrument steriliser
3.	Drums (Assorted Sizes)
4.	Small Wooden Table

OPERATION THEATRE EQUIPMENT

1.	Patients trolly
2.	Operation Table
3.	Shadowless pedestal lamp
4.	Anesthesia Machine, Boyle's apparatus
5.	Anesthesia Trolly
6.	Instrument Trolly
7.	Surgeon's Linan Trolly
8.	Dasin Stand (Single)
9.	A small table for surabbing things brushes etc.
10.	L.V. Stand
11.	Revolving stools
12.	Foot Board
13.	Drum stand for three drums

ANESTHESIA

1. L. P. Needles
2. Intra-trachal tunes (Assorted sizes)
3. L. V. Needles
4. Gordg's Needles
5. Syringes asserted 2, 5, 10 20 cc
6. L. V. Sets (transfusion)
7. Tongue Forceps
8. Lanyngo scope
9. Mouth gag.
10. Toungue holder
11. Sponge Holding forceps
12. B. P. Apparatus
13. Stethescope

Note : USAID Grant funds will not be used for the purchase of equipment for abortion.

State and District Profiles

The Integrated Rural Health & Population Project will be implemented in 13 rural and backward districts in five state : two districts each in Maharashtra (Osmanabad and Parbhani) and Gujarat (Bharuch and Panchmahals), and three districts each in Punjab (Bhatinda, Faridkot and Sangrur), Haryana (Bhiwani, Mohendergarh and Sirsa), and Himachal Pradesh (Hamirpur, Kangra and Sirmur). The districts were selected by the states and endorsed by the GOI on the basis of certain economic and health-related criteria. They include :

i) high proportion of rural population,
ii) high proportion of economically weaker and backward sections of the society
iii) lack of adequate health and family planning infrastructure facilities
iv) high birth rates and
v) high infant mortality rates.

While national-level data is readily available, detailed and reliable district-level data is not always gathered and available in all parts of India. However, site visits were made to each of these districts by the project design team and USAID/India staff during Project Paper development. It was observed that the districts selected required additional inputs.

Among the five states, Himachal Pradesh is the most backward and poor. The state is geographically contiguous with Punjab and Haryana, but is hilly and sparsely populated. It had a population of 3.5 million in 1971 (census). Over 90% is rural. The officially estimated CBR in 1978 was 27.3 and IMR 127. Corresponding all-India figures are : 33.2 and 129 respectively. However, both GOI and state officials believe that the above state figures do not reflect the actual situation and these rates could be considerably higher because of the deficiencies of the Sample Registration Scheme in the state.

The three districts in Himachal Pradesh had a combined population of 1.3 million in 1971 or 38% of the state's population. Rural population varies from 92% to 99%. Over 50% of the population in the project districts belong to backward and economically weaker sections of the society. Reliable vital rates are not available for the districts.

The other two Northern states of Punjab and Haryana are relatively more prosperous. The state of Haryana had a population of 10 million in 1971. Officially estimated CBR in 1978 was 33.4 and IMR 127, which are closer to the national averages. In two of the project districts, however, the CBRs are considerably higher : 42 and 35. In the third district, it is lower than both state and national averages : 29. District level IMRs are not available for Haryana, but in the Project districts they are reportedly higher than the state average. The three districts in Haryana had 20% of the state's population in 1971; about 25-30% have been classified as economically weaker and backward.

The State of Punjab had a population of 13.6 million in 1971. The three districts had a combined population of 3.3 million or 25% of the State population. Punjab's CBR(28.3) and IMR (108) are lower than the national averages. These rates are also lower in the two project districts (CBR 28-30; IMR 103-108). However, according to the special justification provided by the GOI, the above vital rates for the districts do not reflect the actual situation because of the deficiencies in the registration system. The justification indicates that the districts are the most backward in the state in terms of health infrastructure and manpower.

Maharashtra and Gujarat are located in the Western part of the country and are geographically contiguous. Maharashtra had a population of 50.4 million in 1971, making it the third largest state in India. The officially estimated CBR for the state as a whole in 1978 was 26.9 and IMR 83.

The two districts in Maharashtra had a combined population of 2.4 million or 7% of the state population in 1971. About 85 percent is rural. Tribal and economically weaker sections constitute 30-40% of the district's population. The CBRs (33 and 35) are considerably higher than the state figures. The IMRs are lower in the two districts.

The state of Gujarat had a population of 26.7 million in 1971. The officially estimated CBR in 1978 was 35.8 and IMR 146. About 72% of the population is rural.

The two districts of Gujarat had a combined population of 2.96 million or 11% of the state population in 1971. The officially reported CBR for the districts in 1976 were 37 and 39 and IMR 162 and 164. These are considerably higher than both state and national averages. About one-half of the population in the two districts is tribal and backward.

Demographic Indicators - Project States and Districts

Project Districts	1/ Population (000's)	1/ Percentage of Rural Population	Density per Sq. Km.	2/ CBR	2/ CDR	2/ IMR	1/ Dependency Ratio	1/ Literary Rate % Male	1/ Literary Rate % Female	1/ Religion (%) Hindus	1/ Religion (%) Muslims	1/ Religion (%) Others	Doctor/ Pop Ratio (1976)	3/ % couples currently protected (1979)
GUJARAT														
1. Bharuch	1,110	83	123	37.0	18.0	164	64.7	46.4	24.5	83	16	1	1: 5325	44.8
2. Panch Mahals	1,848	89	209	39.4	16.7	162	63.3	33.7	11.2	95	4	1	1: 7559	21.9
State	26,697	72	136	35.8	15.6	146	68.5	46.1	24.8	89	8	3	1: 2628	32.1
HARYANA														
1. Bhiwani	760	86	150	41.5	13.8	NA	NA	36.9	10.2	98	-	2	1:11162	28.2
2. Mohindergarh	730	86	146	35.1	18.1	NA	NA	44.3	12.3	99	-	1	1: 8959	39.6
3. Sirsa	530	85	125	28.6	9.3	NA	NA	31.6	12.4	98	-	2	1:13911	34.6
State	10,040	82	227	33.4	13.3	129.5	85.9	44.0	17.8	89	4	7	1:14256	32.5
HIMACHAL PRADESH														
1. Hamirpur	265	99	237	19.7	7.6	41.8	NA	51.0	28.9	98	-	2	1: 8237	19.8
2. Kangra	800	96	140	28.9	10.0	59.9	NA	47.4	25.6	99	-	1	1: 9792	24.4
3. Sirmur	245	92	87	17.3	4.7	66.8	NA	34.0	12.9	97	-	2	1: 6422	23.7
State	3,460	92	62	27.3	11.6	127.3	NA	45.5	20.2	96	1	3	1: 6484	25.8
MAHARASHTRA														
1. Osmanabad	1,896	88	134	35.0	12.0	72	NA	40.3	14.7	85	10	5	1:10834	29.6
2. Parbhani	1,507	84	121	32.5	12.0	75	NA	36.8	11.2	76	11	13	1:13951	35.8
State	50,400	69	164	26.9	11.6	83	NA	51.0	26.2	82	8	10	1: 865	35.9
PUNJAB														
1. Bhatinda	1,030	82	185	28.0	9.8	107	69	29.0	14.6	23	-	77	1: 5562	37.2
2. Faridkot	1,150	80	200	30.0	10.3	108	70	34.4	21.0	21	-	79	1: 4332	26.7
3. Sangrur	1,150	80	225	28.2	11.3	103	69	30.3	17.0	32	1	67	1: 3651	27.5
State	13,551	76	269	28.3	11.5	103	71	40.4	25.9	37	1	62	1: 2069	27.5
ALL - INDIA	548,160	80	178	33.2	15.0	129	67.1	38.9	18.3	82	11	7	1: 4200	22.1

1/ 1971 census data

2/ CBR, CDR and IMR are based on the Sample Registration Scheme (for the year 1978 or earlier) which is incomplete and deficient for many areas.

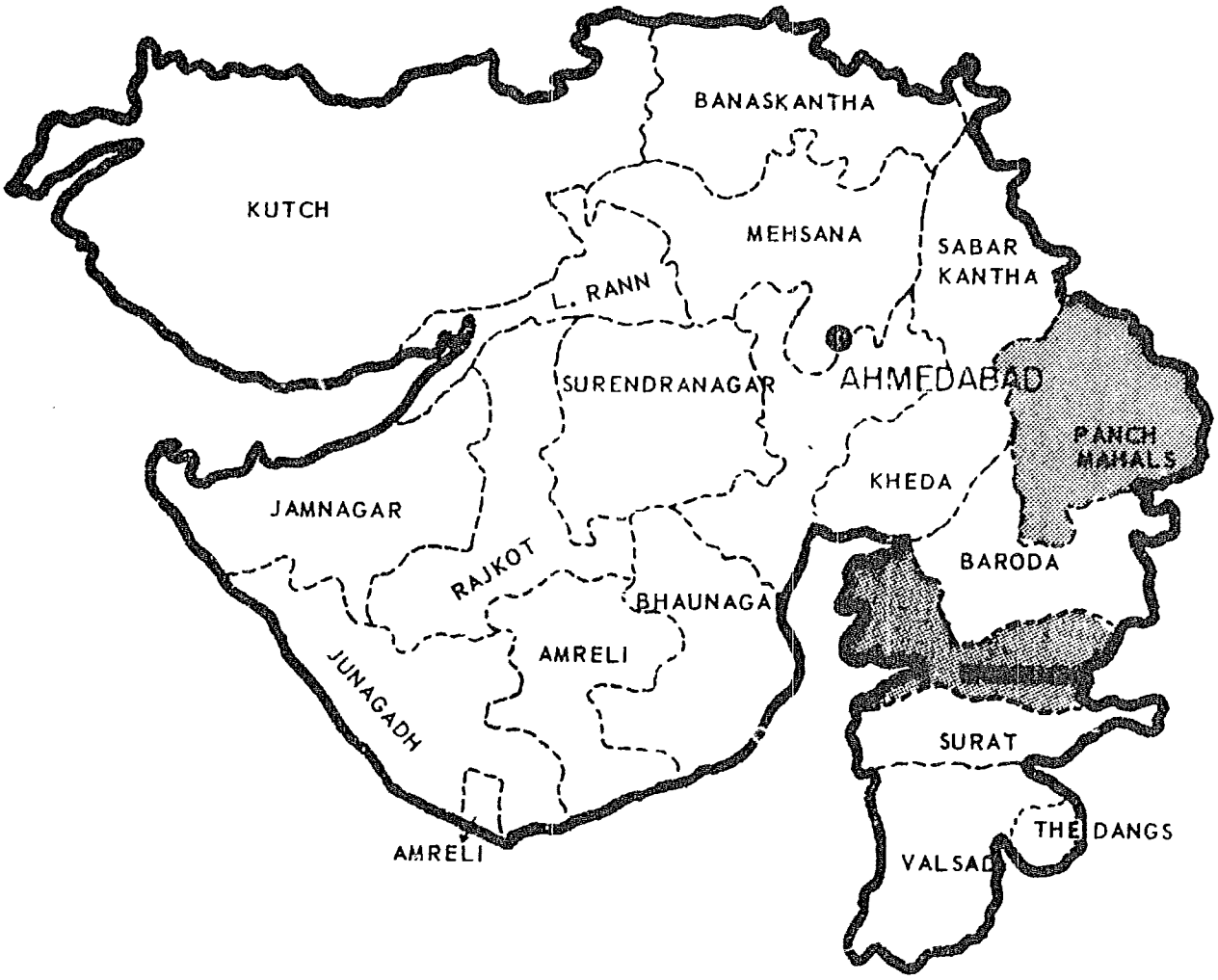
3/ Based on cumulative family planning performance.

HNP:PEBalakrishnan:sg:4/2/80

GUJARAT

USAID / India

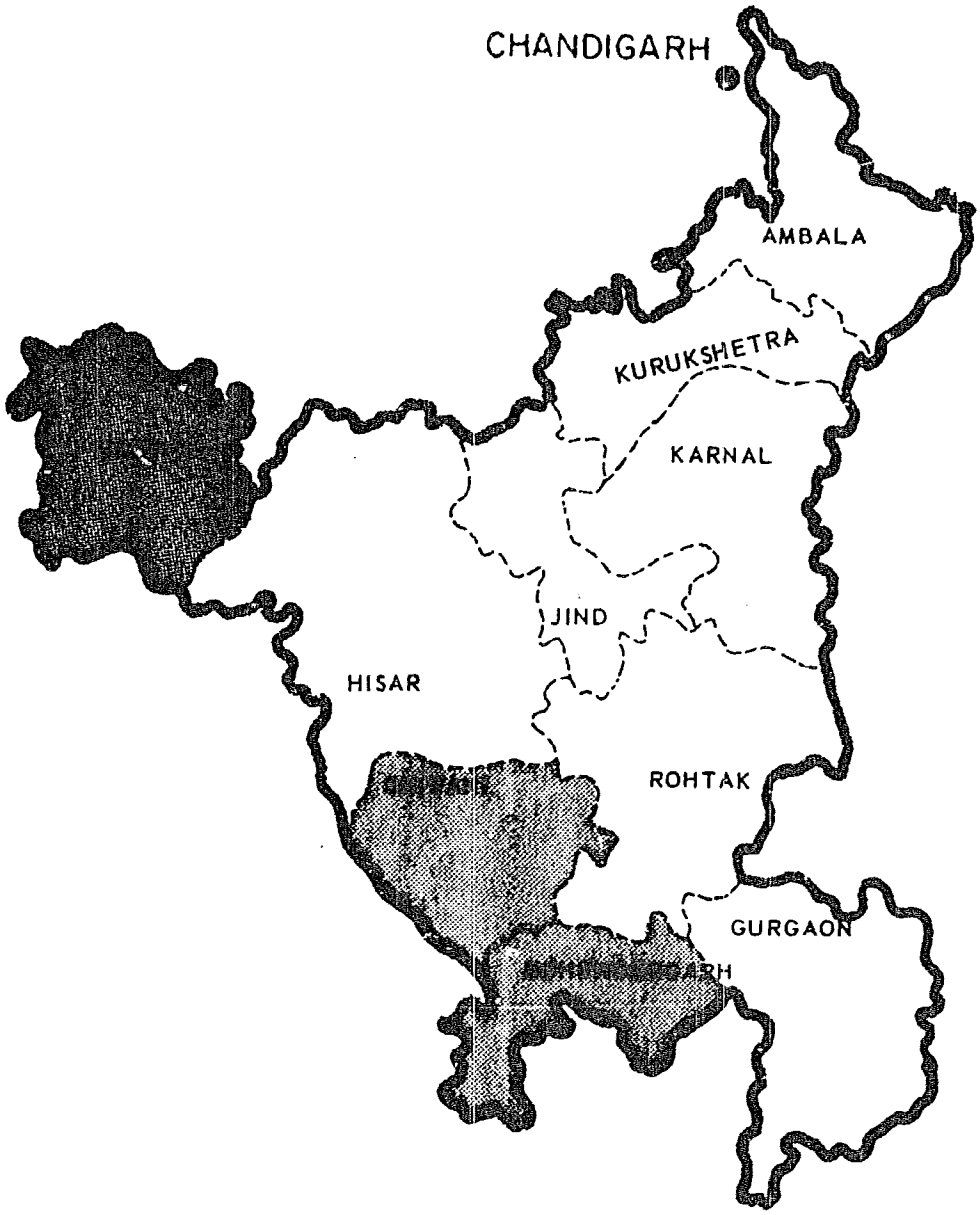
Int. Rural Health/Population
Project Districts



HARYANA

USAID / India

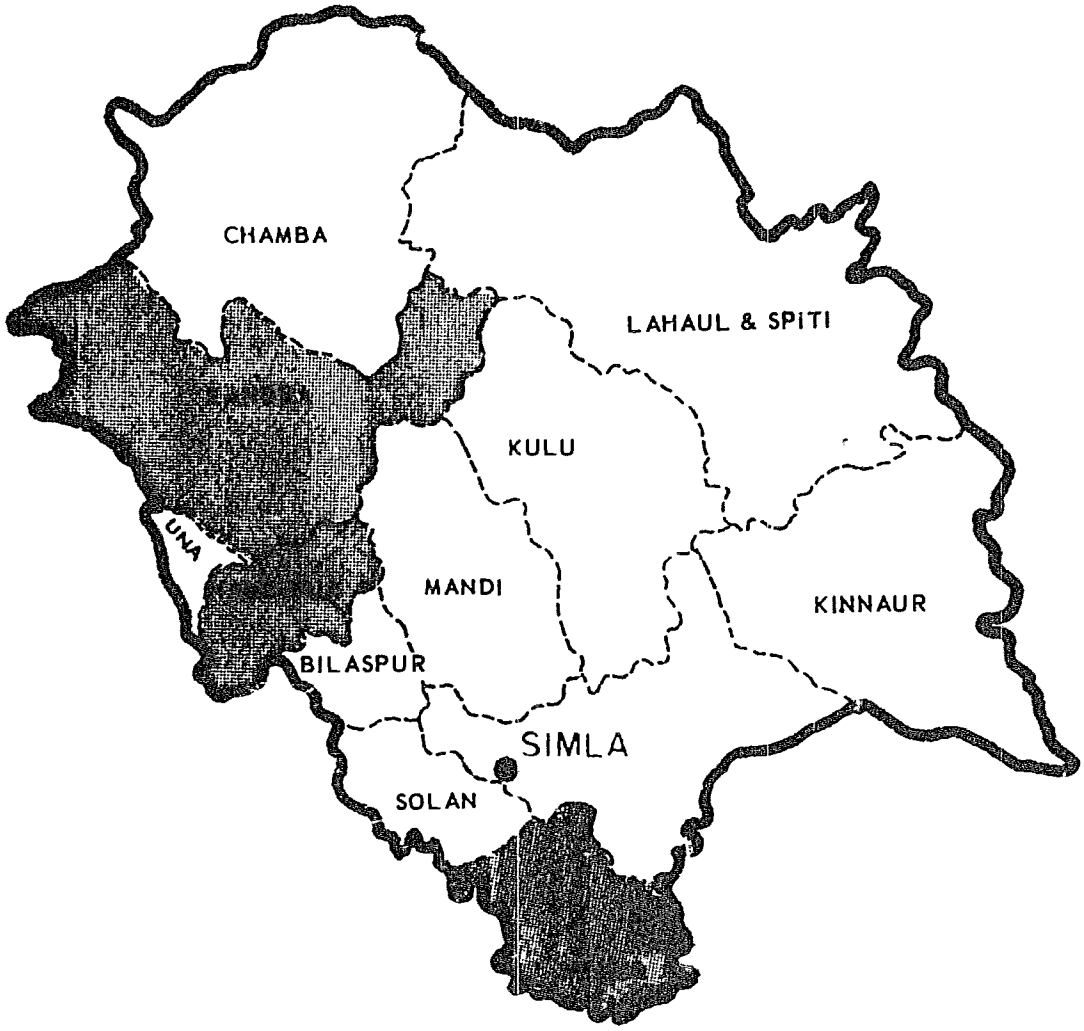
Int. Rural Health/Population
Project Districts



HIMACHAL PRADESH

USAID / India

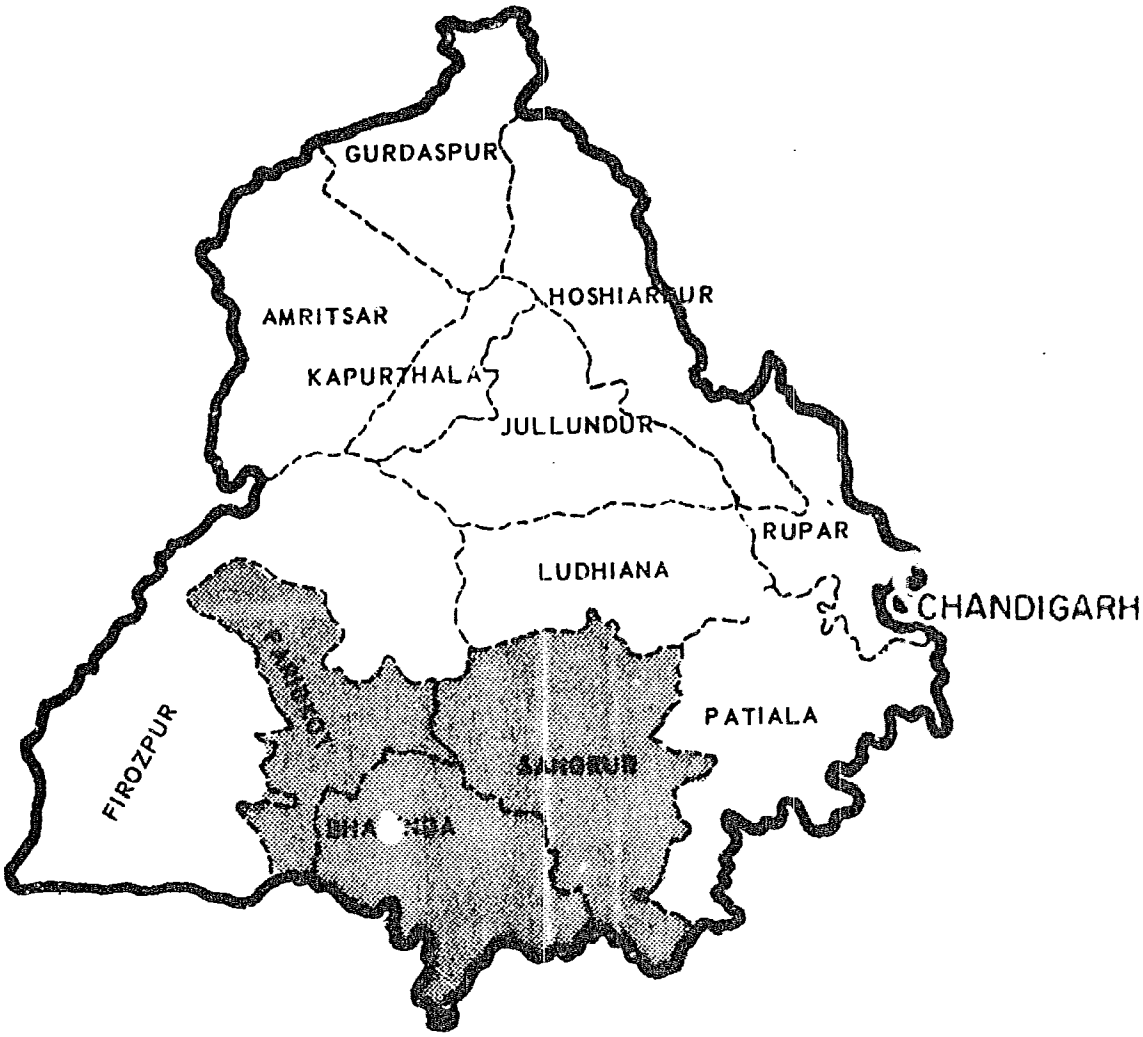
Int. Rural Health/Population
Project Districts



PUNJAB

USAID / India

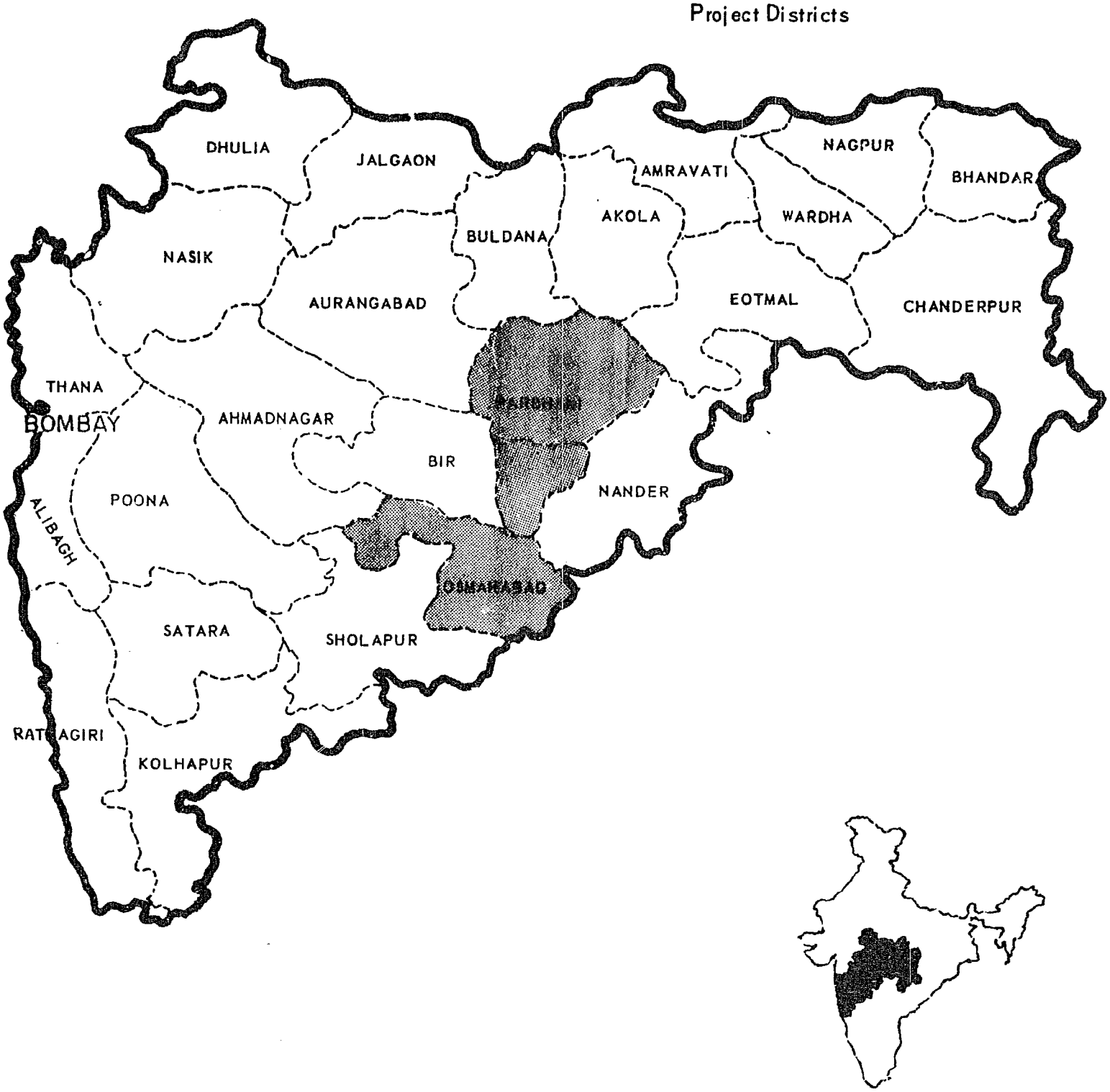
Int. Rural Health/Population
Project Districts



MAHARASHTRA

USAID / India

Int. Rural Health/Population
Project Districts



ENGINEERING ANALYSIS

1. General Description

The engineering and construction phase for AID financing in the 13 selected districts include the following type buildings: Sub-centers, Lady Health Visitor's (LHV) Quarters, Rural Family Welfare Centers (RFWC), Primary Health Centers (PHCs), Upgraded PHCs, Community Hall at Upgraded PHCs, PHC Annexes/Hostel, MHN Training Complex, Transport Workshop, Sub-Division Hospitals, and a State Training Center.

2. General Design, Specification and Cost Estimates

The GOI Ministry of Health & Family Welfare (MOHFW) has developed standard plans for most of the buildings included. States have adopted the standard plans for their design for these buildings with certain variation depending on their requirements and local conditions. Each state Public Works Department's (PWD) architecture and design department is responsible for preparing the detailed drawings on the basis of requirements given by the state health department. The criteria for design used is that buildings are functional and simple in construction. Prime consideration is given to users requirements, health needs, and provision for future expansion, circulation and inter-relationship of space.

The specifications proposed for construction are:

i) Foundation in cement concrete (1:4:8) and brickwork upto plinth level in cement mortar (1:4).

ii) Damp proof course in cement concrete (1:2:4) with bitumen layer at top.

iii) Superstructure in brick masonry or stone masonry with cement mortar (1:6 or 1:4).

iv) Plaster work in cement mortar (1:4 inside, and 1:6 outside).

v) Roofs, slabs, columns, beams and lintels etc. in reinforced cement concrete.

vi) Flooring in ordinary gray cement in all rooms, stone slabs in corridors and verandahs, dado in bathrooms and W.C. Delivery rooms up to ceiling shall have washable surface.

vii) Woodwork: Doors and window frames and joineries in deodar/teak/sal wood, and shutters in deodar/teak/commercial ply.

viii) All surfaces shall be whitewashed in lime. Doors and windows shall be painted.

ix) Local materials such as Mangalore tile roofs instead of concrete slab roofs, lime mortar instead of cement mortar etc. shall be used.

The above specifications are standard specifications and are used in building construction activity all over India. We find these specifications satisfactory.

The simple and basically uniform design will not require any special or unusual site characteristics. Sub-centers will be located in the center of a village to be accessible to the largest possible population and close to public services, utilities and roads, where available. Sites for major buildings will have electricity, water services and good accessibility. Sites are being provided by the community and will not be a cost to the project.

Each state PWD is responsible for preparing cost estimates for all the building activities of the various departments of the state and has prepared a rough cost estimate for the buildings under the proposed project based on agreed upon design criteria. Cost estimates include an annual allowance of 10% for added labor and materials costs due to escalation in prices during the construction period of four years. (For details of costs and areas see the attachment to this analysis.)

3. Construction and Project Management

Bidding and construction procedures will follow the standard practices of the state PWDs using local labor. Bids are invited by the concerned Executive Engineer (EE) by advertisement in leading newspapers and from those contractors and cooperative societies which are registered with the state PWDs. Bidders build up their own premium over the established PWD schedule of rates. The bids are evaluated by the EE and the lowest responsive bidder is awarded the contract. In case bids received are for amounts higher than the estimated cost or no bids are received, the bidding process is repeated once or twice more. If after this, no bids are received, the work is carried out under force account in Haryana, Punjab and H.P.; and on a piece work basis in Gujarat and Maharashtra.

Construction supervision is carried out by the EE of the district PWD. Each district is divided into 8-10 subdivisions depending on the volume of work and is headed by an Assistant Engineer (AE). Each AE is assisted by 4-6 Junior Engineers (JE). In addition, inspectors are hired for full time supervision. The EE, AE and JE monitor the construction periodically.

A detailed review of the project management for implementation of the construction phase of the project has been made. Although the USAID program would constitute only 3-4% of the additional building work load of the State's overall building program each year, the smallness in size of many of the buildings with a large number of the proposed buildings (sub-centers) in rural areas warrants special attention to ensure timely completion of the program.

We have discussed project management issues with the Health Departments of each state as well as the center and also with State PWDs. Agreement has been reached for the creation of special construction cells to carry out the work. A cell will be established in each state with adequate staffing to carry out the responsibility for procuring and supervising construction activities. Each State Ministry of Health will assign a senior official to act as project coordinator with principal responsibility for carrying out all aspects of the project including liason with the construction cell in the PWD departments. (See Implementation Section of Project Paper for details.) During the course of implementation, USAID will ensure that an adequate number of construction cells and staff are provided for the program.

USAID intends to rely mostly on the experience and proven capability of State Health and Public Works Departments for monitoring functions. However, field visits to several randomly selected on-going schemes will be made by USAID representatives to ensure that the various project elements are being implemented in accordance with agreed design and specifications. Such visits will be undertaken in each state at least twice a year by the USAID/Delhi Indian engineer, who is familiar with the technical requirements, and other components for the building construction activities under this project. This engineer will also be responsible for reviewing requests for reimbursement for Project construction elements and for making final recommendations for construction reimbursements.

4. Conclusion

The engineering and construction phase of the project will be implemented in accordance with long established and accepted standards and practices of the state PWDs. Design and cost estimates proposed by the PWD for each state have been reviewed and found reasonable. The creation of a construction cell will ensure implementation in a proper and timely manner. Detailed drawings for each unit proposed for construction will be provided by the States to USAID, for its review and approval, prior to disbursement of funds for construction under this Project.

Annex 6
Attachment

COST ESTIMATES & AREAS PROPOSED ROR C ONSTRUCTION

(Estimated Cost in 000' (Rs.)

(Number of units for each state in parenthesis)

No.	Description	Est.Av. Covered Area Sft.	Total Units	Unit * Cost(Rs.)	Haryana	Punjab	H.P.	Gujarat	Maharashtra	Total Cost (F
1.	Sub Center	450	1,389	45	9,000 (200)	13,365 (297)	7,398 (137)	15,030 (334)	18,945 (421)	63,738
2.	PHCs (new)	7,520	8	881	2,643 (3)	-	5,285 (5)	-	-	7,928
3.	PHCs Partial: i. 50% complete	3,760	23	440	-	-	3,171 (6)	-	7,480 (17)	10,651
	ii.40% complete	4,510	14	528.6	-	7,401 (14)	-	-	-	7,401
4.	PHCs Upgraded	7,250	34	723	3,615 (5)	5,784 (8)	5,205 (6)	5,784 (8)	5,061 (7)	25,449
5.	RFWC Center (new)	2,850	101	320	3,840 (12)	7,680 (24)	8,448 (22)	9,600 (30)	4,160 (13)	33,728
	RFWC Partial 50% complete	1,425	3	160	-	-	-	-	480 (3)	480
6.	LHV Quarters	440	650	34	3,128 (92)	4,828 (142)	4,202 (103)	5,100 (150)	5,542 (163)	22,800
7.	ANM Training Annexes	2,108	16	200	400 (2)	1,200 (6)	720 (3)	1,000 (5)	-	3,320
8.	Training/Community Rooms	1,040	29	100	-	800 (8)	720 (6)	800 (8)	700 (7)	3,020
9.	MMW Training School	-	1	1,407**	-	-	1,407 (1)	-	-	1,407
10.	Regional Family Planning Training Center	-	1	600	-	-	600 (1)	-	-	600
11.	Operating Theatres	-	67	15	150 (10)	195 (13)	126 (7)	360 (24)	195 (13)	1,026
12.	Sub-division Hospital	-	2	1,200	-	-	2,400 (2)	-	-	2,400
13.	Transport Workshop	-	1	180	-	-	180 (1)	-	-	180
					22,776	41,253	39,862	37,674	42,563	184,128

* Base 1979 estimate, 20% added for Himachal Pradesh
** Includes operation cost amounting to Rs.687,000

Total Cost of construction	Rs.184,128,000
Add. cost of initial equipment	13,742,000
Sub-total	197,870,000
Add inflation of 40% for 5 years	79,148,000
Grand Total	Rs.277,018,000
	or $ 34.627.000

PROJECT EXPENDITURES BY STATE BY YEAR - $000's

STATES	PROJECT YEARS					
	(1)	(2)	(3)	(4)	(5)	Total
GUJARAT	2489	2975	3276	2978	3099	14,817
MAHARASHTRA	4573	4216	3855	1990	1994	16,628
HIMACHAL PRADESH	3522	3573	3303	1659	1698	13,755
PUNJAB	2318	2405	1717	1751	1681	9,872
HARYANA	1149	2133	3040	2045	1306	9,673
T O T A L	14051	15302	15191	10423	9778	64,745

PURPOSE 1 - FINANCIAL INPUTS

Additional Trained Workers

				Rs. (000)
1.	CHV's			5,594
	Basic training	600		
	Kits	120		
	Manual	25		
		745 x 5681	= 4,232,345	
	CHV training materials		= 1,362,000	
	G : 462,000			
	M : 363,000			
	HP : 300,000			
	P : -0-			
	H : 237,000			
2.	Dais			4,529
	Basic Training	300		
	Kits	120		
		420 x 9963	= 4,184,460	
	Dais Training Materials		= 345,000	
	G : 93,000			
	M : 72,000			
	HP : 60,000			
	P : 75,000			
	H : 45,000			
3.	FMW's			7,331
	Basic training	1800 x 2770	= 4,986,000	
	FHW training materials		= 2,345,000	
	G : 868,000			
	M : -0-			
	HP : 850,000			
	P : 25,000			
	H : 602,000			

G: Gujarat, M: Maharashtra, HP:Himachal Pradesh
P:Punjab H:Haryana

4. MMW 732

Basic Training 1800 x 330 = 594,000

MMW training materials = 138,000

G : -0-

M : 138,000

HP : -0-

P : -0-

H : -0-

5. LHV's 180

Training Cost

G : 1200 x 150 = 180,000

M : -0-

HP : -0-

P : -0-

H : -0-

TOTAL	18,366
+ 25% inflation	22,958

ADDITIONAL SERVICE FACILITIES & QUARTERS CONSTRUCTED

Rs. (000)

Subcenters — 63,738

Gujarat	:	45,000 x 334	=	15,030,000
Maharashtra	:	45,000 x 421	=	18,945,000
Himachal Pradesh	:	54,000 x 137	=	7,398,000
Punjab	:	45,000 x 297	=	13,365,000
Haryana	:	45,000 x 200	=	9,000,000
				63,738,000

PHC's — 7,928

Gujarat	:	-0-		
Maharashtra	:	-0-		
Himachal Pradesh	:	1,057,000 x 5	=	5,285,000
Punjab	:	-0-		
Haryana	:	881,000 x 3	=	2,643,000
				7,928,000

RWFC's — 33,728

Gujarat	:	320,000 x 30	=	9,600,000
Maharashtra	:	320,000 x 13	=	4,160,000
Himachal Pradesh	:	384,000 x 22	=	8,448,000
Punjab	:	320,000 x 24	=	7,680,000
Haryana	:	320,000 x 12	=	3,840,000
				33,728,000

Upgraded PHC's* — 5,449

Gujarat	:	723,000 x 8	=	5,784,000
Maharashtra	:	723,000 x 7	=	5,061,000
Himachal Pradesh	:	867,000 x 6	=	5,205,600
Punjab	:	723,000 x 8	=	5,784,000
Haryana	:	723,000 x 5	=	3,615,000
				25,449,600

					Rs. (000)
LHV QUARTERS					22,800
Gujarat	:	34,000 x 150	=	5,100,000	
Maharashtra	:	34,000 x 163	=	5,542,000	
Himachal Pradesh	:	40,800 x 103	=	4,202,400	
Punjab	:	34,000 x 142	=	4,828,000	
Haryana	:	34,000 x 92	=	3,128,000	
				22,800,400	
Regional Transport Workshop					180
Himachal Pradesh	:	180,000 x 1	=	180,000	
Initial Equipment					12,402
Sub Center	:	.....	=	5,097,000	
PHC	:	.....	=	545,000	
Upgraded PHC	:	.....	=	6,760,000	
				Construction costs	166,225
				40% inflation	232,715

ADDITIONAL PERSON-YEARS OF WORK

				Rs.(000)
1.	CHV's			27,374
	Medicines	600 p.a.		
	Honorarium	600 p.a.		
		1200 x 22,234 py	= 26,680,000	
	Educational/ Motivational Materials	60 x 11,563	= 693,780	
2.	DAI's			773
	Educational/ Motivational Materials	50 x 15,460	= 773,000	
3.	FMW's			48,400
	Medicines	2000 p.a.		
	Salaries & allowances	7200		
		9200 x 5,258	= 48,374	
4.	MMW's			10,430
	Medicines	1000		
	Salaries and allowances	7200		
		8200 x 1,272	= 10,430,000	
5.	LHV's			10,500
	Salaries and allowances	8000 x 1,307	= 10,456,000	
6.	PHC's			5,020
	a) Staff			
	Gujarat	-0-		
	Maharashtra	2,129,000		
	Himachal Pradesh	1,674,000	= 4,006,000	
	Punjab	-0-		
	Haryana	203,000		

b) Medicines			
Gujarat	-0-		
Maharashtra	750,000		
Himachal Pradesh	90,000	1,014,000	
Punjab	-0-		
Haryana	174,000		
7. Upgraded PHC's			11,931
a) Staff			
Gujarat	3,360,000		
Maharashtra	2,401,000	10,451,000	
Himachal Pradesh	1,890,000		
Punjab	-0-		
Haryana	2,800 000		
b) Medicines			
Gujarat	1,200,000	1,480,000	
Maharashtra	-0-		
Himachal Pradesh	-0-		
Punjab	-0-		
Haryana	280,000		
		Total	114,428
		Inflation @ 25%	28,607
Grand Totals - Purpose 1			143,035

Additional Trained Workers	22,958
Additional Service Facilities and Quarters Constructed	232,715
Additional Person-Years of Work	143,035
PURPOSE 1 TOTALS:	398,708

PURPOSE 2 - FINANCIAL INPUTS

Improved and Expanded Services

			(Rs.000's)
1) Improved services through inservice training			2,304
a) CHV Inservice Training		1,047	
Existing Workers (4 times during the project) Rs. 10/day x 3 days/ year x 4 x 5882 = 705,840			
New Workers (2 times only during the project) Rs. 10 x 3 x 2 x 5681=340,860			
b) DAIS		1,257	
Existing Workers (4 times) Rs. 10 x 3 x 4 x 5497	= 659,640		
New Workers (2 times) Rs. 10 x 3 x 2 x 9963	= 597,780		
c) FMW's	- 0 -		
d) MMW's	- 0 -		
e) LHV's	- 0 -		
f) HA's	- 0 -		
g) MO's	- 0 -		
2) Improved services through research/Innovating activities/contingencies			7,000
estimated at 50% of entire research/ innovative activities budget	Total		9,304

Improved and Expanded Training and Manpower Development

(Rs. 000)

1) Additional Training Facilities Constructed 8,347
+40% Inflator = 11,686

a) ANM training annexes 3,320

Gujarat	:	200,000 x 5	=	1,000,000
Maharashtra	:	-0-		
Himachal Pradesh	:	240,000 x 3	=	720,000
Punjab	:	200,000 x 6	=	1,200,000
Haryana	:	200,000 x 2	=	400,000
				3,320,000

b) Training/community meeting rooms & equipment 3,020

Gujarat	:	100,000 x 8	=	800,000
Maharashtra	:	100,000 x 7	=	700,000
Himachal Pradesh	:	120,000 x 6	=	720,000
Punjab	:	100,000 x 8	=	800,000
Haryana	:	-0-		
				3,020,000

c) MMW training school 1,407

Gujarat	:	-0-		
Maharashtra	:	-0-		
* Himachal Pradesh	:	1,407,000 x 1	=	1,407,000
Punjab	:	-0-		
Haryana	:	-0-		

* Note : 720,000 construction + 687,000 operating costs for five years

d) Regional FP Training Center Hostel Addition 600

Gujarat	:	-0-		
Maharashtra	:	-0-		
Himachal Pradesh	:	600,000 x 1	=	600,000
Punjab	:	-0-		
Haryana	:	-0-		

2)	Research/innovative activities/contingencies training capabilities*	3,500
	* estimated at 25% of entire research/innovative activities budget	
	TOTAL	15,186

IMPROVED AND EXPANDED COMMUNICATIONS

	(Rs. 000's)
1) Training Camps	2,581
2) Support for communications training for block and district communications staff (BEE, DEE)	
3) Support for communications training for field workers from other Government Departments	
4) Support for strengthening block and district level IEC organizations	13,503*
5) Support for development of school population education program	
6) Innovative communications activities/contingencies	
7) Information and motivation materials exhibition Unit for upgraded PHCs	370**
Total	16,454

Camps

Gujarat	:	2911 x 200	=	582,000
Maharashtra	:	2796 x 200	=	560,000
Himachal Pradesh	:	1700 x 200	=	384,000
Punjab	:	3360 x 200	=	678,000
Haryana	:	1877 x 200	=	377,000

* IEC Lump-sum			**UPHCs Exhibition Unit
Gujarat	:	3,000	160
Maharashtra	:	2,940	35
Himachal Pradesh	:	1,616	150
Punjab	:	3,322	-
Haryana	:	2,625	25
		13,503	370

EXISTING SERVICE FACILITIES RENOVATED

(Rs.000's)

1)	PHC's				18,052
	Gujarat	:	-0-		
	Maharashtra	:	440,000 x 17 =	7,480,000	
	Himachal Pradesh	:	528,600 x 6 =	3,171,600	
	Punjab	:	528,600 x 14 =	7,400,400	
	Haryana	:	-0-		
				18,052,000	
2)	Operating theater additions plus equipment				1,026
	Gujarat	:	15,000 x 24 =	360,000	
	Maharashtra	:	15,000 x 13 =	195,000	
	Himachal Pradesh	:	18,000 x 7 =	126,000	
	Punjab	:	15,000 x 13 =	195,000	
	Haryana	:	15,000 x 10 =	150,000	
				1,026,000	
3)	Subdistrict hospital renovations				2,400
	Gujarat	:	-0-		
	Maharashtra	:	-0-		
	Himachal Pradesh	:	1,200,000 x 2 =	2,400,000	
	Punjab	:	-0-		
	Haryana	:	-0-		
4)	Equipment and supplies for operation theater				1,340
	Gujarat	:	20,000 x 24 =	480,000	
	Maharashtra	:	20,000 x 13 =	260,000	
	Himachal Pradesh	:	20,000 x 7 =	140,000	
	Punjab	:	20,000 x 13 =	260,000	
	Haryana	:	20,000 x 10 =	200,000	
				1,340,000	
5)	RWFC				480
	Maharashtra	:	160,000 x 3 =	480,000	
				TOTAL	23,298
				+40% Inflator	32,617

IMPROVED AND EXPANDED MONITORING, RESEARCH AND EVALUATION

(Rs.000's)

1) Project management at district level — 7,225

a) Staff

Gujarat	:	1,450,000	
Maharashtra	:	1,060,000	
Himachal Pradesh	:	1,080,000	6205
Punjab	:	1,500,000	
Haryana	:	1,115,000	

b) Office rent and contingencies

Gujarat	:	110,000	
Maharashtra	:	120,000	
Himachal Pradesh	:	250,000	840
Punjab	:	180,000	
Haryana	:	180,000	

c) Office furniture and supplies

Gujarat	:	30,000	
Maharashtra	:	40,000	
Himachal Pradesh	:	60,000	180
Punjab	:	30,000	
Haryana	:	20,000	

2) Project management at the state level — 8,883

a) Staff

Gujarat	:	1,680,000	
Maharashtra	:	1,343,000*	
Himachal Pradesh	:	1,380,000	8153
Punjab	:	2,180,000	
Haryana	:	1,570,000	

b) Office rent and contingencies

Gujarat	:	50,000	
Maharashtra	:	-0-	
Himachal Pradesh	:	50,000	440
Punjab	:	170,000	
Haryana	:	170,000	

(Rs. 000's)

c) Office supplies and equipment

Gujarat	:	30,000	290
Maharashtra	:	-0-	
Himachal Pradesh	:	200,000	
Punjab	:	30,000	
Haryana	:	30,000	

* details not given, may include office rent and office supplies and equipment categories.

3) Transport

a) at PHCs

Gujarat

Vehicles*	:	60,000 x 37= 2,220,000	
POL	:	-0-	

Maharashtra

Vehicles*	:	70,000 x 18= 1,260,000	
POL	:	-0-	8,632

Himachal Pradesh

Vehicle*	:	70,000 x 20= 1,400,000
POL	:	-0-

Punjab

Vehicles	:	70,000 x 31= 2,170,000
POL	:	-0-

Haryana

Vehicles	:	7,000** x 5=	35,000
	:	70,000* x 19=	1,330,000
POL	:	-0-	-0-
			1,365,000

* replacement of existing vehicles so no POL costs to project

** motorcycles

(Rs. 000's)

b) at Upgraded PHC

Gujarat

Vehicles	:	60,000 x 8	=	480,000
POL	:	-0-		

Maharashtra

Vehicles	:	70,000 x 7	=	490,000
POL	:	-0-	=	210,000
				700,000

2,240

Himachal Pradesh

Vehicles	:	70,000 x 6	=	420,000
POL	:	-0-	=	240,000
				660,000

Punjab

Vehicles	:	-0-
POL	:	-0-

Haryana

Vehicles	:	80,000 x 5 ***	=	400,000
POL	:	-0-		

*** ambulances

c) at District Level

Gujarat

Vehicles	:	60,000 x 2	=	120,000
POL	:	7,000/year x 5 years x 2 vehicles	=	70,000
				190,000

Maharashtra

Vehicles	:	70,000 x 2	=	140,000
POL	:	7000 x 5 x 2	=	70,000
				210,000

(Rs.000's)

Himachal Pradesh 1,623

Vehicles	:	70,000 x 3	=	210,000
POL	:	-0-	=	150,000
				360,000

Punjab

Vehicles	:	70,000 x 3	=	210,000
POL	:	7000 x 3 x 5	=	105,000
				315,000

Haryana

Vehicles	:	70,000 x 3	=	210,000
POL	:	7000 x 5 x 3	=	150,000
mobile maintenance units			=	188,000
				548,000

d) at State level

Gujarat

Vehicles	:	60,000 x 2	=	120,000
POL	:	7000 x 5 x 2	=	70,000
				190,000

Maharashtra 535

Vehicles	:	-0-
POL	:	-0-

Himachal Pradesh

Vehicles	:	70,000 x 1	=	70,000
POL	:		=	50,000
				120,000

Punjab

Vehicles	:	70,000 x 1	=	70,000
POL	:	7000 x 5 x 1	=	35,000
				105,000

Haryana

Vehicles	:	70,000 x 1	=	70,000
POL	:	10000 x 5 x 1	=	50,000
				120,000

(Rs.000's)

4) Management information systems development* 8,400

Gujarat	:	1,500,000
Maharashtra	:	1,500,000
Himachal Pradesh	:	2,400,000
Punjab	:	1,500,000
Haryana	:	1,500,000

* includes management analysis, training and systems development: a further budget breakdown will occur after the analysis phase.

5) Monitoring and evaluation 4,650

Gujarat	:	1,000,000
Maharashtra	:	1,000,000
Himachal Pradesh	:	900,000
Punjab	:	1,000,000
Haryana	:	750,000

6) Research/innovative activities/contingencies* ** 3,500

		Entire research/Innovative activities budget	
Gujarat	:	3,500,000	
Maharashtra	:	3,000,000	
Himachal Pradesh	:	2,500,000	14,000
Punjab	:	3,000,000	
Haryana	:	2,000,000	

* For descriptive purposes, allocated as 50% to services, 25% to training, 25% to management, already communications has research/innovative activities included.

** Allocation to management

TOTAL 45,688

GRAND TOTALS - PURPOSE 2

	(Rs.000's)
Improved and Expanded services	9,304
Improved and Expanded Training and Manpower Development	15,186
Improved and Expanded Communications	16,454
Existing service facilities renovated	32,617
Improved and Expanded Monitoring, Research, and Evaluation	45,688
Purpose 2 Totals	119,249

SUMMARY TOTALS

	Rs.(000)	$(000)	%
Purpose 1	398,708	49,839	77%
Purpose 2	119,249	14,906	23%
Project Grant Total	517,957	64,745	100%

ADMINISTRATIVE ARRANGEMENTS FOR PROJECT IMPLEMENTATION

1. GOI & States

USAID will depend on the proven ability of the GOI and the State Governments for the implementation of this Project. The organisation of the Central and State Ministries of Health and Family Welfare and the district level health and family planning set up are given in the attached charts. However, for proper planning and coordination of the Project, special 'Project Offices' will be established at the district and state levels. In addition, 'Project Advisory Committees' are proposed to be set up at the district, state and central levels for reviewing the progress of the Project and for rendering timely advice to the Project staff. Specific responsibilities and administrative arrangements envisaged at the various levels are as follows:

Center :

The GOI Ministry of Health & Family Welfare will be responsible for overall coordination of all the activities proposed under the project and for ensuring that the terms of the Project Agreement are fully met. The Ministry will designate a senior officer of the rank of Joint Secretary to be the Central Coordinator. He will be assisted by an Assistant Commissioner and other staff. The Central Coordinator and his staff are permanent employees of the Ministry and will spend only part-time on the Project.

In addition, the Ministry will set up a Central Project Advisory Committee which will meet annually to review Project progress and to render guidance to the States. This Committee will be chaired by the Secretary or Additional Secretary-cum-Commissioner for Family Welfare and will have the following as members : (a) a representative from the Planning Commission, (b) a representative of the Ministry of Finance (DEA), (c) the State Health Secretaries and State Directors of Health Services (d) the Central Project Coordinator and (e) representatives from USAID/New Delhi and AID/Washington. The Committee will review the annual reports from the States and approve district action plans and budgets for the following year.

States :

The five States will be responsible for the implementation of the Project in their respective districts. Each state will establish a Project Director, of the rank of Special or Joint Secretary, who will be respon-

sible for all aspects relating to this project at the State level. The State Project Office will consist of three separate "cells" : (a) a Planning & Implementation Cell, (b) a Research & Evaluation Cell, and (c) a Construction Cell. The Planning & Implementation and Research & Evaluation Cells will have two or three technical officers and supporting staff. The Construction Cell will have two or three engineers. It may be located in the State Public Works Department, which will be responsible for all construction activities, but the head of this cell will report directly to the State Project Director. The entire expenses of the State Project Office will be met out of the Project funds.

In addition to the Project Office, each state will set up a Project Governing Board which will meet quarterly to review the progress of the Project in the respective districts and to approve plans for the next quarter. This Board will be Chaired by the State Chief Secretary so as to ensure proper coordination and support of all Departments associated with the implementation of the Project and will have the following as members : (a) Secretary (Health), (b) Director of Health Services, (c) a representative from the Planning Commission, (d) a representative from the State PWD, and (e) the Project Director. USAID Representatives will be invited to the meetings of the State Governing Boards.

Districts :

The Chief District Medical Officers of Health will be responsible for implementing the Project in their respective districts. The Chief Medical Officer will be assisted by a Project Officer who will head the District Project Office. Each District Project Office will have four separate cells : (a) Planning & Implementation Cell, (b) Research & Evaluation Cell, (c) Information and Communications Cell, and (d) Construction Cell. Each cell will have one or two technical officers and supporting staff. The construction cell may be located in the District PWD or Zila Parishad (in Gujarat and Maharashtra) but the head of this cell will report to the District Project Officer. All expenses of the District Project Officer and his staff will be met by the Project.

In addition to the District Project Office, a District Project Advisory Board will be established to review the progress of implementation of the Project. This Committee will be chaired by the District Collector who is in-charge of all development activities in a district. The Committee

will meet once a month and will consist of the following : District Collector (Chairman), Chief Medical Officer of Health District Development Officer, District PWD Engineer, District Education Officer, District Public Health Nurse (all members) and the District Project Officer who will serve as Member-Secretary.

Blocks :

At the block level, the existing Block Development Board is expected to supervise the implementation of the Project and to ensure the coordination of all departments at this level.

During PP development, the existing organizational set up and technical resources, particularly at the district and block levels, were carefully reviewed by the PP design team and USAID/India staff. While these were found to be generally satisfactory, vacancies and the lack of an adequate management information system were found to be serious problems. As part of the Project implementation plan, the GOI and the States have agreed to fill all existing vacancies on a priority basis during the first year of the Project and to maintain optimum staff levels during the rest of the Project period. The proposed Management Information System under the Project will address the second problem. The additional project staff and advisory committees should further strengthen the management capability at the district and state levels.

2. USAID Administrative Arrangements

a. Disbursements

The total cost of the Project is $64,745,000 of which AID's contribution in the form of grant is $40,000,000. AID plans to finance portions of costs of specified Project activities as shown in the Financial Analysis section of this paper. Certain expenditures relating to Project planning and management will be eligible for AID reimbursement retroactively from April 1, 1980. These expenditures will be specified in a Project Implementation Letter. The eligibility date for other expenditures will be indicated in the Grant Agreement.

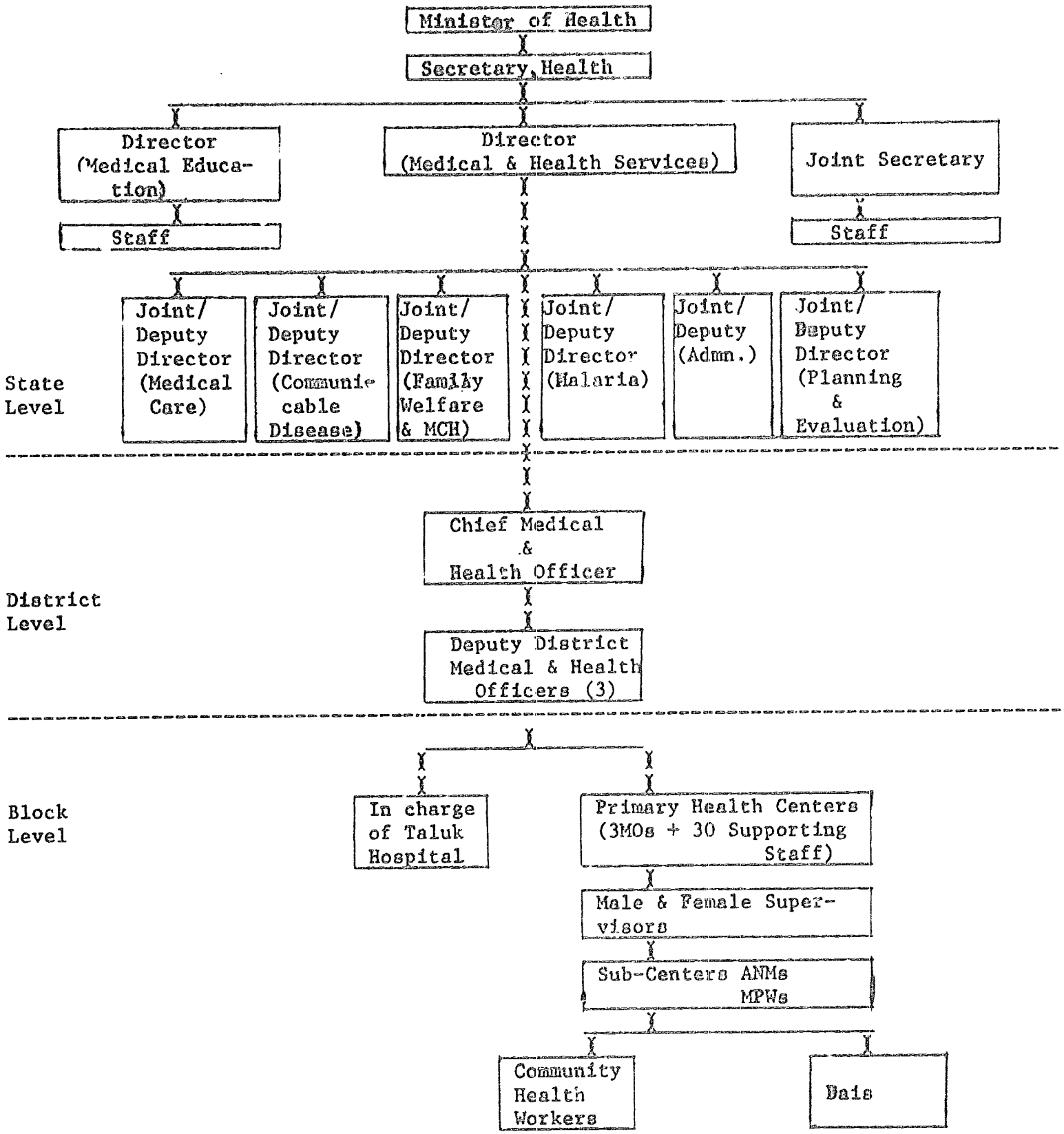
Disbursements by AID under this Project will be made against the submission of Voucher Form SF 1034 which will be supported by expenditure statements. The detailed procedure for claiming advance and reimbursements of funds will be described in a Project Implementation Letter.

b. Project Monitoring

USAID will rely mostly on the proven monitoring capability of the GOI and the States and the special GOI/State administrative arrangements mentioned earlier for Project monitoring. As far as possible, USAID's monitoring functions will be coordinated with those of the States and GOI. However, it is envisaged that USAID office of Health and Population and Engineering Staff will make periodic site visits to the project districts. USAID representatives will also participate in the State-level quarterly project review meetings. In addition, both AID/W and USAID officials will attend the annual Project review meetings in New Delhi.

Current and proposed USAID/India staff will be adequate for Project monitoring.

STATE HEALTH & FAMILY WELFARE ORGANIZATION



PRIMARY HEALTH CENTER

PHC

(1 for 80-100,000 population)

- 3 Medical Officers
- 1 Sanitary Inspector
- 1 Public Health Nurse/ Lady Health Visitor
- 1 Auxiliary Nurse-Midwife
- 1 Block Extension Educator
- 1 Sanitary Inspector
- 1 Lab. attendant
- 1 Compounder
- 1 Store keeper
- 4-5 Supporting staff

- 1 Male (HA)
- 1 Female Supervisor (LHV)

(For 20,000 population)

Sub - Center

(For 5,000 population)*

- 1 Male (MPW)
- 1 Female (ANM) Multipurpose worker

*For 3,000 population in tribal/hilly areas

Village	Village	Village	Village	Village
1 CHV	1 CHV	1 CHV	1 CHV	1 CHV
1 TBA(Dai)	1 TBA(Dai)	1 TBA(Dai)	1 TBA(Dai)	1 TBA(Dai)
(1000 pop.)	(1000 pop.)	(1000 pop.)	(1000 pop.)	(1000 pop.)

Implementation Plan By Project Activity

An implementation plan by project year appears in Part IV:B of the Project Paper. The following tentative implementation schedule is derived from the plans submitted to the GOI by the states.

Activity Area 1 : Project Management

The administrative arrangements for the project have been described in Part IV:A of the PP and also in Annex 7. As shown on the bar charts on the following pages, selection and orientation of the staff is expected to take about five months.

By the sixth month of the project, the Indian institutions and consultants, who will be associated with the Project, should have been selected and contracts signed. Many of the groups will have been chosen before the sixth month or may have been involved in the design of the baseline surveys and needs assessments.

The baseline surveys and needs assessments should be completed by the end of the first project year. They will include a pretesting phase, a data gathering phase, and an analysis and report writing phase. All of these phases will be completed by the end of the first Project year.

Annual reviews are planned beginning a the end of the fifth project quarter. The first annual review will be held after the baseline survey and assessment reports are completed and the states have prepared detailed plans for the remaining four years of the project. The annual reviews are then expected yearly with the second annual review also serving as the mid-project evaluation. This review should occur not later than January of 1983 so that similar new projects of this type can be planned for FY 1983 if there is mutual interest.

The end of project evaluation should occur beginning at least nine months before the project ends to allow sufficient time for data gathering, analysis, and final report writing.

Activity Area 2 : Construction

Construction is a major component of the project and will require considerable planning and management by the states to insure timely

completion of the work. There are many different types of buildings and many are remote and small in size. For this reason, Construction Cells are to be set up at the state and district levels to manage this component. It is important to coordinate the completion of buildings, the arrival of supplies and equipment, and the end of training for the workers so that immediate match-up can occur between a new worker; a new building, and adequate supplies and equipment

As it seems important to increase access as rapidly as possible and to have a back-up unit for the village-level workers, perhaps subcenter construction and LHV quarters construction should be given first priority followed by FMW annexes at PHCs, other additional buildings and renovation of existing buildings. These schedules need further discussion with state officials which will occur soon after the Project Agreement is signed.

Activity Area 3 : Training

Training in this project will be extensive and variable. The first step is a training needs assessment to determine the needs of service workers, managers, communicators, and the trainers themselves. The objective of this assessment, to be completed by about the end of the 9th project month, will be to develop a profile of needs from which a training plan for the life of the project can be developed. Present GOI plans are that the basic training courses for village-level workers will be completed by the end of the third project year (late 1983). In-service "refresher" training courses for all service workers is an important part of this Project and should begin in the second year after the training needs assessment suggests priority training areas. It should then occur yearly.

Activity Area 4 : Communications

The communications needs assessment should be complete by the 9th project month and will be used to make profiles of communications needs in project - assisted districts from which local communications plans can be developed. The orientation camps will continue as they are now and incorporate new ideas and plans as they become available.

Activity Area 5 : Management

The needs assessment will help determine both management training needs and management systems development needs. The development of the management information system (MIS) will require a clear definition of priority areas. MIS development takes much time if done properly

and includes the development of indicators, design of recording and reporting forms, pretesting, revisions, fieldtesting for extended periods of time (two or more reporting periods), training of personnel in the new system, and then phased implementation.

In addition to the MIS, the states have indicated a desire to strengthen their capabilities at field-oriented research and innovative activities. These will occur throughout the life of the project but may be expected to begin after the baseline surveys and needs assessments.

Project Management
PROJECT ACTIVITY

TASKS	YEAR 1				YEAR 2				YEAR 3				YEAR 4 & 5			
Qtr →	1	2	3	4	1	2	3	4	1	2	3	4	1-2	3-4	1-2	3-4
Selection and Orientation of project staff by states																
Selection of Indian institutions and consultants by GOI/states for surveys and needs assessments																
Design and pretesting of baseline survey and needs assessments																
Data gathering, analysis and reports																
Detailed state action plans																
CALENDAR YEAR		1981				1982				1983				1984		1985
US FISCAL YEAR	1981				1982				1983				1984		1985	
GOI FISCAL YEAR	80 - 81		81 - 82				82 - 83			83 - 84				84-85		85-86

Project Management/Construction
PROJECT ACTIVITY

TASKS	YEAR 1				YEAR 2				YEAR 3				YEAR 4 & 5			
Qtr →	1	2	3	4	1	2	3	4	1	2	3	4	1-2	3-4	1-2	3-4
Annual Reviews																
Mid-project evaluation																
End-of-project evaluation																
Construction																
Set-up of construction Cells																
a) Subcenters and LHV quarters																
b) PHCs/Upgraded PHCs																
c) Rural Famil Welfare Centers																
d) FMW training annexes																
CALENDAR YEAR		1981				1982				1983			1984		1985	
US FISCAL YEAR	1981				1982				1983				1984		1985	
GOI FISCAL YEAR	80 - 81		81 - 82				82 - 83				83 - 84			84-85		85-86

Construction/Training
PROJECT ACTIVITY

TASKS	YEAR 1				YEAR 2				YEAR 3				YEAR 4 & 5			
Qtr →	1	2	3	4	1	2	3	4	1	2	3	4	1-2	3-4	1-2	3-4
e) Training/Community halls					———	———	———	———	———	———	———	———	———	———	———	———
f)MMW training center (1)					———	———	———	———	———	———	———					
g)Regional Family Planning Training Center (1)					———	———	———	———	———	———	———					
h)[illegible] subdistrict hospital renovations					———	———	———	———	———	———	———	———	———	———	———	———
Training																
Courses for trainers, mangers, and communications specialists			———	———			———	———			———	———		———		———
Basic training courses for village-level workers	———	———	———	———	———	———	———	———	———	———	———	———				
CALENDAR YEAR	1981				1982				1983				1984		1985	
US FISCAL YEAR	1981				1982				1983				1984		1985	
GOI FISCAL YEAR	80 - 81		81 - 82				82 - 83				83 - 84		84-85		85-86	

Training/Communications
PROJECT ACTIVITY

TASKS	YEAR 1				YEAR 2				YEAR 3				YEAR 4 & 5			
Qtr →	1	2	3	4	1	2	3	4	1	2	3	4	1-2	3-4	1-2	3-4
Basic training courses for paramedicals																
In-service "refresher" training courses for workers																
Communications																
Orientation camps for village and block leaders																
Orientation for field workers from other government departments																
CALENDAR YEAR		1981				1982				1983				1984		1985
US FISCAL YEAR	1981					1982				1983			1984		1985	
GOI FISCAL YEAR	80 - 81		81 - 82				82 - 83				83 - 84			84-85		85-86

Management Systems

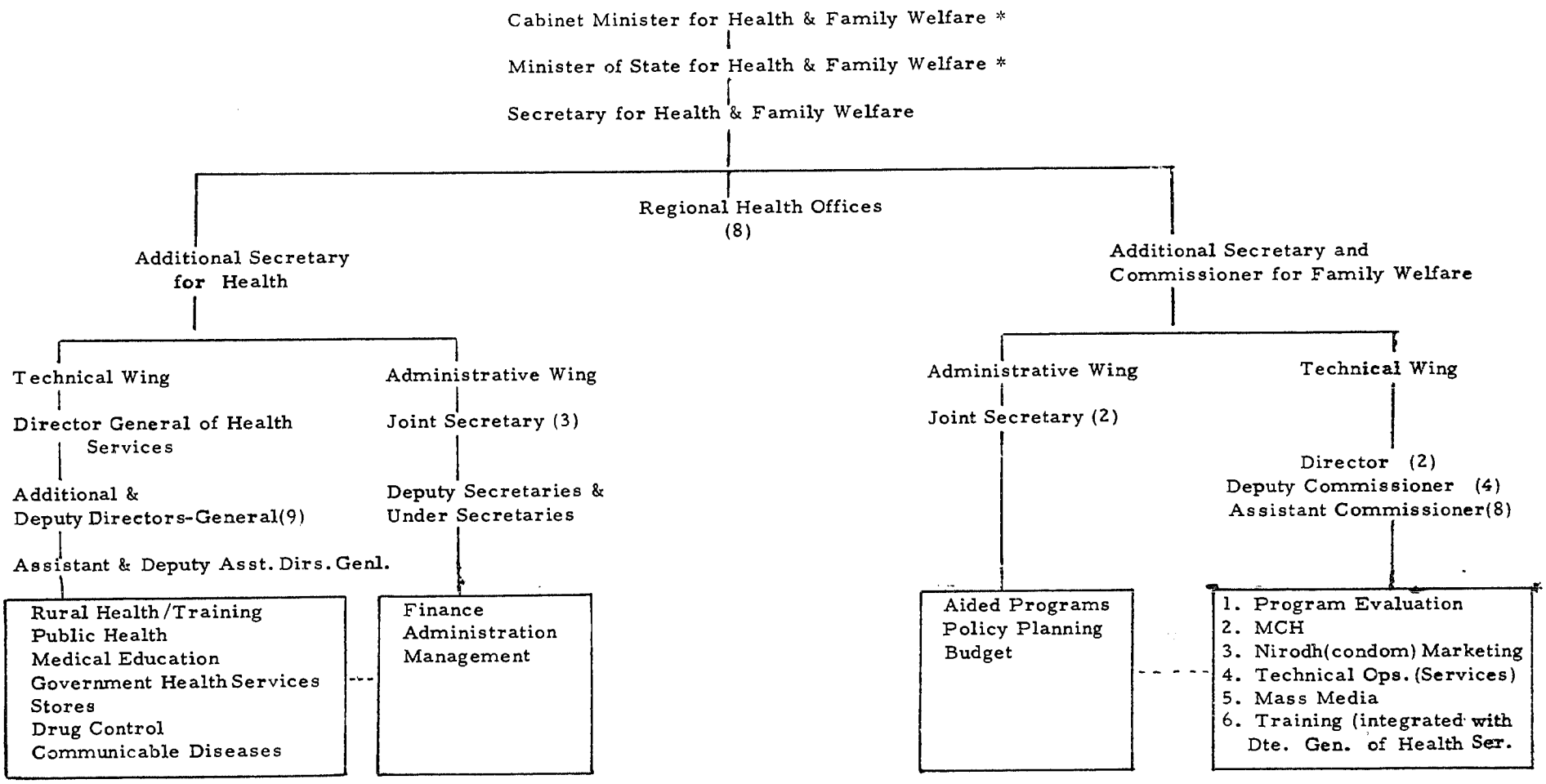
PROJECT ACTIVITY

TASKS	YEAR 1				YEAR 2				YEAR 3				YEAR 4 & 5			
Qtr →	1	2	3	4	1	2	3	4	1	2	3	4	1-2	3-4	1-2	3-4
Management systems																
Management Information systems development																
Management Information systems implementation																
Research and Innovative studies																

CALENDAR YEAR		1981				1982				1983				1984		1985
US FISCAL YEAR	1981				1982				1983				1984		1985	
GOI FISCAL YEAR	80 - 81		81 - 82				82 - 83				83 - 84			84-85		85-86

Simplified Organization Chart of

CENTRAL MINISTRY OF HEALTH & FAMILY WELFARE



* Political appointees; all others are permanent civil servants.