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AGENCY FOR INTERNATIONAL DEVELOPMENT

Washington, D.C. 20523

PROJECT PAPER

INDIA  
AIDS PREVENTION AND CONTROL (APAC)  
386-0525

APPENDIX 3A, Attachment 1  
Chapter 3, Handbook 3 (TM 3:43)

AGENCY FOR INTERNATIONAL DEVELOPMENT  
**PROJECT DATA SHEET**

1. TRANSACTION CODE  A = Add  C = Change  D = Delete  
Amendment Number \_\_\_\_\_ DOCUMENT CODE **3**

COUNTRY/ENTITY **INDIA**

3. PROJECT NUMBER **386-0525**

4. BUREAU/OFFICE **ASIA**

5. PROJECT TITLE (maximum 40 characters) **AIDS PREVENTION AND CONTROL (APAC)**

6. PROJECT ASSISTANCE COMPLETION DATE (PACD) MM DD YY **11 23 91**

7. ESTIMATED DATE OF OBLIGATION (Under 'B' below, enter 1, 2, 3, or 4)  
A. Initial FY **91** B. Quarter  C. Final FY **97**

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

A. FUNDING SOURCE	FIRST FY			LIFE OF PROJECT		
	B. FX	C. L/C	D. Total	E. FX	F. L/C	G. Total
AID Appropriated Total	268	1,852	2,120	468	9,532	10,000
(Grant)	( 268 )	( 1,852 )	( 2,120 )	( 468 )	( 9,532 )	( 10,000 )
(Loan)	( )	( )	( )	( )	( )	( )
Other U.S. 1.						
2.						
Host Country		500	500		7,000	7,000
Other Donor(s)						
<b>TOTALS</b>	<b>268</b>	<b>2,352</b>	<b>2,620</b>	<b>468</b>	<b>16,532</b>	<b>17,000</b>

9. SCHEDULE OF AID FUNDING (\$000)

A. APPROPRIATION	B. PRIMARY PURPOSE CODE	C. PRIMARY TECH CODE		D. OBLIGATIONS TO DATE		E. AMOUNT APPROVED THIS ACTION		F. LIFE OF PROJECT	
		1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan
(1) PN						200		2,000	
(2) HE						1,320		3,000	
(3) AIDS						600		5,000	
(4)									
<b>TOTALS</b>						<b>2,120</b>		<b>10,000</b>	

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

11. SECONDARY PURPOSE CODE

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

A. Code \_\_\_\_\_ B. Amount \_\_\_\_\_

13. PROJECT PURPOSE (maximum 480 characters).

The purpose of the project is to introduce and reinforce Human Immunodeficiency Virus (HIV) preventive behavior in the at risk population.

14. SCHEDULED EVALUATIONS

Interim MM YY **09 94** Final MM YY **11 29 96**

15. SOURCE/ORIGIN OF GOODS AND SERVICES

000  941  Local  Other (Specify) \_\_\_\_\_

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

Clearance: CO/A: NNWahi *WLB*

17. APPROVED BY *Walter G. Bollinger*

Signature *Walter G. Bollinger*  
Title **Director**

Date Signed MM DD YY **06 23 92**

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

MM DD YY \_\_\_\_\_

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## PROJECT AUTHORIZATION

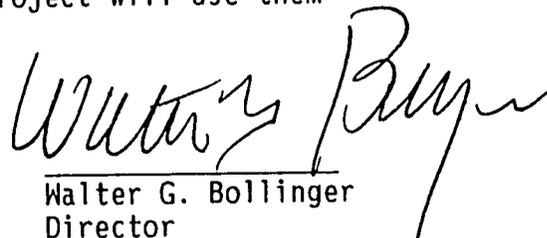
Country: INDIA  
Project: AIDS PREVENTION AND  
CONTROL (APAC) PROJECT  
Number: 386-0525

1. Pursuant to Section 104 of the Foreign Assistance Act of 1961, as amended, I hereby authorize the AIDS Prevention and Control (APAC) Project for India (the "Cooperating Country") involving planned obligations of not to exceed Ten Million United States Dollars (\$10,000,000) subject to the availability of funds in accordance with the annual OYB allotment process, to help in financing the local currency and foreign exchange costs of the Project. The planned life of the Project is seven years from the date of initial obligation.

2. The Project is designed to assist the Government of India (GOI) in reducing the spread of the Human Immunodeficiency Virus (HIV) infection. It will support non-governmental organizations (NGOs) in extending the reach of the GOI National AIDS Control Program in the areas of condom promotion and distribution, behavior changes, and improvements in treatment of sexually transmitted diseases (STDs). The Project will work in the Indian State of Tamil Nadu and will coordinate closely with the State level program.

3. Source, origin and nationality of Goods and Services: Goods and services financed by A.I.D. under the Project shall have their source, origin and nationality in the United States or India. Local source procurement is authorized pursuant to Handbook 1B, Section 5. D. 10a. (1) (e) for project costs of approximately Ten Million U.S. Dollars (\$10,000,000) for administration of the project, including the provision of technical assistance, training and commodities. Local procurement is required because of the unique nature of the project in that the achievement of project objectives requires that local expertise and commodities be used to the maximum extent possible. The majority of project funds will be sub-granted to indigenous NGOs to assist them in administering AIDS prevention activities in the Indian State of Tamil Nadu. Mission experience in India indicates that the chances of success in achieving project objectives are greatly enhanced if local organizations and expertise are used to the maximum extent possible. Such organizations and expertise do exist, and the project will use them to maximize its chances of success.

Signature:

  
Walter G. Bollinger  
Director

Date:

June 23, 1992

## LIST OF ACRONYMS

AID	U.S. Agency for International Development
AIDS	Acquired Immune Deficiency Syndrome
AIDSCAP	AIDS Control and Prevention Project, Washington,DC
APAC	AIDS Prevention and Control Project, USAID/India
ARF	AIDS Research Foundation of India
CCC	Christian Counseling Center
CDTR	Center for Development, Training and Research
CHAD	Community Health and Development program
CHV	Community Health Volunteer
CHW	Community Health Worker
CMAI	Christian Medical Association of India
CMC	Christian Medical College, Vellore
CME	Continuing Medical Education
CPA	Certified Public Accountant
DANIDA	Danish Agency for International Development
DESH	Deepam Education Society for Health
EEC	European Economic Community
EMMA	Education Mass Media Association
ESI	Employer's State Insurance plan
FRC	Foreign Currency Registration certification
FP	Family Planning
FPAI	Family Planning Association of India
FTEs	Full-Time Equivalents
GIRHFW	Gandhigram Institute of Rural Health & Family Welfare
GPA	Global Program on AIDS, WHO
GOI	Government of India
GOTN	Government of Tamil Nadu
GP	General practitioner
HIV	Human Immunodeficiency Virus
ICCW	Indian Council for Child Welfare
IEC	Information, Education and Communication
IG	Inspector General (AID)
ITC	Indian Tobacco Company, officially ITC
KABP	Knowledge, Attitudes, Beliefs and Practices
LOP	Life of Project
MCCSS	Madras Christian Council for Social Service
MCH	Maternal and Child Health
MIS	Management Information System
MMC	Madras Medical College
MOHFW	Ministry of Health and Family Welfare
MSSW	Madras School of Social Work

MTP	Medium Term Plan
NGO	Non-governmental organization
NORAD	Norwegian Agency for Development Cooperation
NSS	National Service Scheme
ODA	Overseas Development Administration, UK
PP	Project Paper
PHC	Primary Health Center
PIR	Project Implementation Review
PPI	Priority Prevention Indicator
PVO	Private Voluntary Organization
RIG	Regional Inspector General (AID)
SIAPP	South Indian AIDS Action Program
SIDA	Swedish International Development Agency
SOC SEAD	Sisters of the Cross Society for Education and Development
STD	Sexually Transmitted Disease
TINP	Tamil Nadu Integrated Nutrition Project
TRC	Tuberculosis Research Center, Madras
UNDP	United Nations Development Program
USAID	U.S. Agency for International Development, India
VDRL	Venereal Disease Research Laboratory
VHAI	Voluntary Health Association of India
WID	Women in Development
WHO	World Health Organization
VHS	Voluntary Health Services, Madras
YWCA	Young Women's Christian Association

## I. SUMMARY

The AIDS Prevention and Control Project (APAC) is a seven year project with a budget of \$10 million that is designed to assist the Government of India to reduce the spread of the Human Immunodeficiency Virus (HIV) infection. The Project will support non-governmental organizations (NGOs)<sup>1</sup> to extend the reach of the Government of India (GOI) National AIDS Control Program in the areas of condom promotion and distribution, behavior change, and improvements in the treatment of sexually transmitted diseases (STDs). The Project will work in the State of Tamil Nadu and will coordinate closely with the State level program.

The goal of the APAC Project is to reduce sexual transmission of HIV in Tamil Nadu. The GOI estimates that there are currently between 300,000 and one million HIV infected persons in India. Just over 100 AIDS cases have been officially reported since the first case in 1987, however, it is projected that by 1995, there will be 60,000 cumulative cases of AIDS. If the current rate of infection continues, the epidemic in India may become one of the largest in the world. Tamil Nadu is one of three states in the country with the highest prevalence of HIV infection.

The Project is designed to change behavioral norms through selective interventions that have been identified as the most effective in reorienting populations to practice HIV preventive behavior. APAC will target high risk populations, including prostitutes and their clients, and STD patients. Grants to NGOs will be provided to educate target populations, to promote and sell condoms, and to enhance STD services and counseling.

The Project will support NGOs implementing these activities by helping them to design and evaluate their activities, by developing Information, Education, and Communication (IEC) materials and training aides for their use, and by facilitating an increased distribution of socially marketed and commercial condoms. APAC will also fund a major media campaign promoting condoms that will reinforce the interpersonal communications activities of the NGOs, and sponsor research that provides information essential to increasing the effectiveness of Project interventions.

The Project will be directed by a Project Management Committee (PMC) headed by a representative of the Government of Tamil Nadu (GOTN) with representation from USAID, the GOI, and Voluntary Health Services, Madras (VHS). The PMC will establish guidelines for implementing each of the components, and identify, select and fund organizations and individuals carrying out APAC-supported activities. USAID will negotiate with the Government of India to enter into a Cooperative Agreement with VHS to manage the Project,

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<sup>1</sup>The term non-governmental organizations (NGOs) refers here to a broad range of private sector entities, including registered voluntary organizations with health and/or community development objectives, private organizations such as marketing or advertising firms, universities, and professional and trade organizations.

coordinate closely with the GOTN, the GOI, and USAID, and ensure the technical integrity of these activities. A core staff of six persons will include the APAC Director, specialists in IEC, STDs, condom logistics, research, and an accountant.

## 2. PROJECT RATIONALE

### 2.1. Background

In 1981, the first clinical cases of AIDS were described in the medical literature in the United States. In 1985, HIV screening was initiated at two sites in India. In 1986, the first HIV infection was detected in an asymptomatic prostitute in Tamil Nadu. In 1987, the first case of AIDS was identified in Bombay.

As of January 1992, 103 cases of AIDS had been officially reported to the National AIDS Control Program. Thirteen of these cases were foreigners. Of the 90 Indian cases, 59 (65%) were considered heterosexually promiscuous, 23 (25%) were among blood donor/recipients, and 8 (9%) were intravenous drug users. Of the 59 heterosexual cases, 19 were STD clinic patients and 22 were female prostitutes.

To date, a total of 1,227,829 blood samples have been screened by 62 HIV testing surveillance sites throughout the country. Of these, 6,683 have been shown to be seropositive for the virus, with confirmation by Western Blot testing. HIV positive cases have been found in 21 of the 23 states in India. A breakdown of the seropositive cases shows that 47% were heterosexually promiscuous males and prostitutes, 14% were blood donors or recipients<sup>2</sup>, and 21% were intravenous drug users. All of these groups are at high risk for HIV transmission. Thus, this rate of seropositivity should not be considered representative of the general adult population of the country.

The GOI estimates that there are currently between 300,000 and one million HIV infected persons in India. It is projected that by 1995, there will be 60,000 cumulative cases of AIDS. If the current rate of infection continues, the epidemic in India may become one of the largest in the world.

In India, as elsewhere, AIDS primarily affects people 14-45 years of age located in industrial and commercial centers, and these people are key to economic development. The World Health Organization (WHO) estimates that 15 to 20% of the work force

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<sup>2</sup>Researchers are beginning to investigate the hypothesis that the professional blood donors who are testing HIV positive are, as a group, more sexually promiscuous than the general population. If they are, then the estimated ratio of sexual transmission of HIV in India increases.

in Africa could die in the next decade, resulting in a large number of HIV infected children and "AIDS orphans". Considering that India has more than twice the population of sub-Saharan Africa, the potential magnitude of human suffering from HIV/AIDS is enormous.

Soon after the first case of AIDS was identified in India in 1987, the Government of India made AIDS control a high priority and began planning and implementing HIV/AIDS prevention and control activities. These efforts were primarily directed at establishing HIV testing centers to ensure blood safety and diagnostic capability.

In January 1990, the Ministry of Health and Family Welfare (MOHFW) published the outline of a three year Medium Term Plan for AIDS (MTP) developed in collaboration with the WHO. The plan included substantial provisions for health and sex education, behavior modification, control of STDs, improvement of diagnostic facilities and prevention of transmission through blood and blood products. It also specifically supported the involvement of NGOs to reach high risk populations (e.g., prostitutes and their clients.)

Subsequently the MOHFW expanded the MTP and developed the National Strategic Plan for the Prevention and Control of AIDS in India: 1992 - 1996, with a budget of \$100 million. Implementation of the five year plan is scheduled to begin in 1992.

## 2.2. Conformity with GOI Strategy and Programs

### 2.2.1. The Strategic Plan (1992-1996)

The long term objectives of the GOI National Strategic Plan are: 1) Prevention of HIV transmission in India, 2) Reduction of morbidity and mortality associated with HIV infection, and 3) Minimization of the social and economic impact resulting from HIV infection. There are seven components to the Plan:

**Program Management:** Four coordinating bodies will be formed at the national level: 1) National AIDS Committee, representing Ministries, NGOs, and private organizations which will ensure coordination of activities; 2) National AIDS Control Board consisting of high level Ministry officials to oversee program funding and policy; 3) National Program Coordinating Team to implement program activities; and 4) National Advisory Committee to provide technical support. At the State level, an AIDS Cell, consisting of three to five technical staff, will be responsible for planning, implementing and coordinating prevention and control activities in each State.

**Surveillance and Research:** A targeted surveillance program will monitor the epidemic and provide necessary information to support program direction and mobilize political and social leaders.

**HIV Prevention through Behavior Change:** To include general media campaigns, targeted interventions for high risk groups, social mobilization, training, operational research, and evaluation and monitoring. This component will be closely linked with all other components of the program.

**STD Control:** Existing government STD control programs will be revitalized and pilot programs will be initiated in the major metropolitan areas.

**Condoms:** To strengthen public and private efforts to optimize the availability and use, by people at risk, of good quality latex rubber condoms for the prevention of STD/HIV.

**Blood Safety:** To develop and strengthen the national blood transfusion system and ensure safety and efficacy of blood and blood products.

**Reduction of Impact:** Services will be improved or developed to provide counseling to HIV infected individuals and their families, and to establish a capability to care for patients which will include community-based care.

The APAC Project strategy is consistent with the objectives of the National Strategic Plan and will address most, but not all, program priorities. The Project will focus on known strategies to reduce the sexual transmission of HIV among high risk groups. A.I.D. is the lead donor in this approach and has demonstrated the capability of bringing a rapid concentration of resources to prevention activities for high risk groups in various parts of the world. It will not support surveillance, blood safety, or care of HIV infected persons.

### 2.2.2. Other Donor Activities

Other donors are contributing to HIV/AIDS prevention and control activities:

**The World Bank** is providing a loan of \$84 million over five years to support implementation of the National Strategic Plan. WHO is the executing agency, providing technical assistance to the GOI and a contribution of \$1.5 million. The GOI contribution will be \$13.5 million.

Of special relevance to APAC, at the state level this Project will support the establishment of AIDS Cells to direct the use of World Bank loan funds in the areas of blood supply, surveillance, STD treatment, IEC and NGO participation. The Cell in Tamil Nadu is expected to be established in 1992. The loan agreement will also assist the GOI to improve the standard of condoms produced in India to meet WHO specifications which will in turn directly benefit the APAC Project.

**United Nations Development Program** will be performing assessments prior to the preparation of their Fifth Country Program. Currently UNDP is focusing on building awareness about AIDS and its economic impact among national planners.

**UNICEF** plans to provide a total of \$10 million on Information, Education and Communication (IEC) for AIDS in India.

**The European Economic Community** intends to fund AIDS education activities in Bombay budgeted at about \$700,000.

**The Norwegian Agency for Development Cooperation (NORAD)**, with a contribution of \$1.3 million, has created an AIDS NGO Cell to fund NGO activities throughout the country. NORAD has also supported study tours, such as the recent trip to Zambia, of policy makers, government leaders and representatives of NGOs. NORAD plans to put \$1 million into AIDS in India on an annual basis through a follow-on to the AIDS-Cell Project.

**Swedish International Development Agency** has provided approximately \$250,000 multilaterally and is considering a donation of \$1 million next year.

**The Overseas Development Administration** plans to provide approximately \$3 million for AIDS activities in West Bengal between 1992-5.

**The Danish Agency for International Development (DANIDA)** has requested the Danish Government's permission to undertake an AIDS program in India. The size and focus of the program have not been decided but indications are that it will be in Tamil Nadu and/or Orissa where DANIDA supports programs in leprosy control and rehabilitation and in the care and rehabilitation of the handicapped.

**The Ford Foundation** is funding Population Services International to carry out condom distribution and awareness building among high risk groups in Bombay and to encourage the print media to pay more attention to AIDS. In Tamil Nadu they are supporting Christain Medical College in Vellore, the South Indian AIDS Association in Tamil Nadu, and the AIDS Research Foundation. Ford Foundation priorities for what totals approximately \$300,000 of support are: education/IEC, particularly with youth, prostitutes and their clients, and college students; training, mainly of health workers; advocacy; strengthening STD services; research on sexual behavior; and condom social marketing.

**PANOS, a London-based NGO, is focusing on: publication of HIV/AIDS materials; issues concerning women and AIDS; economic impact of AIDS research; and media awareness activities.**

### 2.3. Conformity with USAID Objectives and Strategies

By directly affecting the economically productive segment of society, by placing unparalleled demands on the health care system, and by creating additional economic burdens generated by orphans and other dependents, the AIDS epidemic could wipe out the gains of several decades of public health programs and potentially retard the general development of the country. Two of the three program objectives of USAID could be affected adversely by this epidemic: increased productivity of Indian enterprises, and smaller, healthier families. It will be absolutely essential to prevent the spread of AIDS in India in order to ensure that these objectives are achievable.

The Project will work in the State of Tamil Nadu and will provide support to NGOs that will implement a range of activities to achieve these strategies. By supporting NGOs and promoting partnerships among the GOTN, NGOs and the private sector, the Project will complement and strengthen the state and national prevention and control efforts. If efficient methods of financing NGO activities are identified, using NGOs to implement project activities will ensure that high risk groups are reached most effectively. NGOs are based in the community, are sensitive to attitudes and behaviors of their catchment populations, they communicate well with the people they serve, and they can call on private resources to augment their programs. GOI and GOTN statements in public and donor fora over the last year have underlined a confidence in the NGO approach and A.I.D. experience has shown NGO involvement to be key in prevention strategies. This NGO approach is consistent with the USAID program intervention strategy to achieve its smaller, healthier families program objective.

Tamil Nadu, a state with 56 million inhabitants, was chosen as a focus for the Project because it is one of three states in the country demonstrating a rapid increase in HIV infection among high risk groups (the others are Maharashtra and Manipur). Available data from Tamil Nadu indicate that heterosexually promiscuous groups, such as prostitutes and STD clinic attenders, have the highest seropositive rates, with blood donors and recipients next in prevalence. In studies performed in 1990 and 1991 in Madras, 10% to 16% of the prostitutes tested were found to be infected with HIV, a dramatic increase from approximately 1% prevalence found in 1987 in this group. Among STD clinic attenders, HIV seropositivity in 1986 was 1%. In data generated in 1990 and 1991, the HIV seropositivity rate of STD clinic attenders was between 5% and 10%. The epidemiology of AIDS indicates that if these rates of increase in infection continue, the disease will threaten the general population.

Concentrating on the state of Tamil Nadu allows the Project to effectively follow the spread of infection to and from different areas of the state as well as into and out of the state. It allows the Project to coordinate closely with: GOTN, and in turn GOI, objectives in the area of AIDS prevention. And, the state focus allows USAID to provide a defined and significant contribution to the National program.

### 3. PROJECT GOAL, PURPOSE AND OUTPUTS

#### 3.1. Project Goal

The goal of the APAC Project is to reduce sexual transmission of HIV in Tamil Nadu.

Prevention of HIV infection is the only approach to controlling AIDS. There is no known cure for the disease; no medical prophylaxis is available. Sexual transmission is the most important mode in Tamil Nadu, probably accounting for at least 80% of cases. Therefore, APAC will target populations at highest risk for sexual transmission, focusing on changing behavior and encouraging safe sexual practices.

The GOI has in place an HIV surveillance system at the national and state level which measures HIV and syphilis rates among antenatal clinic attenders. Therefore, data will be available on trends in HIV infection in the general population in Tamil Nadu. However, it is expected that little measurable change will occur in the next two to three years. A more sensitive marker of HIV prevalence early in the epidemic will be HIV positivity in "high risk" groups, such as prostitutes and STD patients. These data are already routinely collected by state centers and reported to the National AIDS Control Program for public use.

An early measure of the efficacy of the APAC Project will be STD prevalence and incidence. Data from the existing surveillance system showing annual or semi-annual changes in syphilis rates among antenatal clinic attenders will provide a relatively sensitive indicator of the effectiveness of STD prevention and control, and will serve as a proxy indicator of behavior changes affecting HIV transmission.

#### 3.2. Project Purpose

The purpose of the Project is to introduce and reinforce HIV preventive behavior in the at risk population. APAC will support NGOs to educate target populations, promote and sell condoms, enhance STD services and counseling. APAC will also support research that provides information essential to increasing the effectiveness of Project interventions. APAC activities will reach large numbers of people in high risk populations with messages that are designed to improve their knowledge of HIV and STDs and motivate them to practice safe sexual behavior.

### 3.3. Project Outputs

The following outputs are expected to be achieved by the APAC Project:

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#### PROJECT OUTPUTS

- Total condom sales in Tamil Nadu will increase by 15% per year, which translates to an additional 70 million condoms over the life of the project.
- There will be sustained condom distribution in at least 55,000 retail outlets and in 80% of NGOs that are involved in AIDS prevention.
- A network of at least 100 NGOs will be actively involved in AIDS prevention activities.
- There will be increased awareness of HIV/STD preventive measures and condom use among high risk populations due to NGO activities that reach three million people over the life of the project.
- An STD clinical management and counseling module will have been developed and at least 500 individuals trained in STD clinical management and counseling.
- Fifteen behavioral and operations research studies will be completed and the findings disseminated to policy-makers and program managers.

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For the first two Outputs, Tamil Nadu has a head start. Private and social marketing condom sales totalled approximately 25 million pieces in 1991 in Tamil Nadu and sales appear to be increasing by approximately 6% per year. To reach a rule-of-thumb sales rate for an AIDS prevention program of 15% per year, the Project will need to promote the sales of an additional 70 million condoms over the life of the Project. In terms of sales outlets, an estimated 50,000 retail outlets are selling condoms in Tamil Nadu today. The Project will encourage sustained sales in those outlets as well as sales in an additional 5,000 new outlets, and ensure that condoms are distributed to high risk populations in at least 80% of Project-supported NGO activities.

For the remaining outputs, the Project will need to start from scratch. Knowledge of HIV and preventive strategies is found to be very low among high risk groups, few NGOs are involved with AIDS prevention activities, no comprehensive STD clinical management and counseling module exists (though the state has a strong history of STD control work in the public sector), and research on high risk groups that is applicable to AIDS prevention activities is badly lacking.

## 4. STRATEGIC APPROACH

### 4.1. Target Populations

Evidence demonstrates that in the early stages of an AIDS epidemic, the greatest impact on the spread of the disease is achieved by focusing prevention activities on groups at high risk of becoming infected with HIV. In Tamil Nadu these groups include prostitutes, their clients, and other people with multiple sex partners who reside in urban and peri-urban areas. APAC will concentrate its activities on these groups, and use extant data on infection rates to monitor and, if necessary, to amend the targeting strategy.

While not considered core transmitters of HIV, two additional groups will be viewed by the Project as particularly vulnerable: adolescents and female partners of males who engage in high risk behavior. It is acknowledged that providing sex education to adolescents is difficult in the Indian context, yet it is important to develop innovative programs that will foster safe sexual behavior in this age group at a time when patterns are being established that will continue into adulthood. Female partners of males who engage in high risk behavior are a potential conduit for perinatal transmission of HIV. They need to increase their general health-seeking behavior for the treatment of STDs.

### 4.2. Major Interventions

The Project will seek to prevent the transmission of HIV through promotion and distribution of condoms, and improvement of STD services. Education leading to the behavior change required for increased condom use and health seeking behavior with regard to STD treatment will support these two major interventions.

#### 4.2.1. Promotion and Distribution of Condoms

Using condoms is the only known physical barrier method of preventing the transmission of HIV, and as such the promotion and distribution of condoms to high risk groups will be a major thrust of the APAC Project.

The condom is well known in India as a contraceptive device, but not as a protection against sexually transmitted diseases. The challenge for the APAC Project lies in making manufacturers, marketers, health providers and the consuming public understand and accept the notion of using condoms for disease prevention without stigmatizing their use.

**A two-pronged approach** will be initiated to increase the use of condoms:

- A major **generic condom promotion** campaign, that includes mass media and interpersonal communication, will be designed and targeted to the high risk groups.
- A **focused effort to increase the accessibility of condoms** will be initiated. The effort will necessitate the forming of partnerships and pooling of resources among non-profit, for profit and governmental agencies.

The Project will support a major generic condom promotion effort that associates condoms with the prevention of sexually transmitted diseases and HIV, and encourages use. Messages promoting condoms as a "double protection" to prevent STDs and for family planning will be evaluated, as will the introduction of a universal logo for all condoms distributed or sold. This intensive campaign will be reinforced by the interpersonal communication and distribution of condoms NGOs.

APAC will involve the condom manufacturers and social marketing groups in planning the campaign strategy and will negotiate partnership agreements specifying their contributions and complementary promotional activities. It is anticipated that the campaign will stimulate sales and thus attract additional support from the commercial sector to promote generic condom use and advertise commercial brands. Gradually, the commercial sector will take over all of the promotion.

To increase accessibility of condoms to high risk groups, APAC will support effective low cost approaches to augmenting the existing distribution system for socially and commercially marketed condoms, using NGO and existing government outreach programs, as well as the pharmaceutical industry, and commercial and public sector manufacturers.

The Project will also fund condom education, promotion and distribution activities undertaken by NGOs, thus extending the distribution system to target groups in the community and the workplace. The network of sales points will be expanded to non-traditional outlets, such as public and private STD clinics, hospitals, health centers, blood banks, bars, lodging houses, truck stops, railway and bus stations, factories, cinema houses and community centers.

#### 4.2.2. STD Services

The presence of sexually transmitted diseases, particularly genital ulcer disease, increases the efficiency of HIV transmission 5 to 20 times. In addition, IEC activities that target high risk "core transmitter groups," such as STD patients, can have up to eight times as large a preventive impact as those aimed at the general population. Thus, improving access to and quality of STD case management is an important intervention for decreasing the transmission of HIV.

The prevalence of sexually transmitted diseases (STDs) in both the general population and among high risk groups in Tamil Nadu is increasing. In the 1970s rates of syphilis among antenatal mothers were estimated to average 1/5 of a percent; today the average rates range from 2 to 5%.<sup>3</sup> Among prostitutes, STD infection is highly endemic, with gonorrhea, trichomoniasis, syphilis, chancroid and chlamydial infection probably present in more than half of very young prostitutes<sup>4</sup> at any one time. STD experts in Tamil Nadu estimate that every day some 1500 to 3000 new STD infections occur in Madras and that 1 in 25 adults in urban areas have an STD.

Tamil Nadu has an extensive government STD clinical infrastructure to the level of the district hospitals. This infrastructure serves about 10% of symptomatic STD patients. Most patients prefer to seek help from private clinicians, traditional healers and "quacks."

For APAC, prompt treatment with highly effective drugs on the basis of initial syndrome diagnosis of STD's is the cornerstone of the STD strategy. Even when lab support, such as syphilis serology and gonorrhea culture, is available, treatment can be started at the initial clinic visit, while lab confirmation of diagnosis is pending. Specifically, syndrome diagnosis and treatment should be implemented for genital ulcer disease in men and women, urethral discharge in men and vaginal discharge in women. When available, microscopic examination for *T. vaginalis* in women, *Neisseria gonorrhoea* in men, and the darkfield exam for *T. palladium* will serve as a useful adjunct to syndrome diagnosis of vaginal discharge, urethral discharge in men and genital ulcer disease.

The objectives of the Project's STD component are to make STD services more accessible, and to improve the quality of STD services for high risk groups.

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<sup>3</sup>As a point of comparison, in selected countries in Africa in which HIV prevalence is high, syphilis rates among the general population range between five and 15 percent.

<sup>4</sup>It is easier to discern these diseases among the young because of the ulcerations which are visible at the earlier stages of the disease.

To improve access, the Project will:

- Make a concerted effort to establish new clinical sites for STD treatment especially for prostitutes, other high risk groups and women. Existing worksite based clinic facilities and Employee State Insurance and NGO based clinical facilities would be encouraged to provide STD services and referral.
- Encourage innovative approaches to delivering clinical services, like the establishment of reproductive health centers with franchises in high risk urban slums or male-only clinics offering services for STDs, urology, sexual dysfunction, and family planning.
- Improve STD recognition and case management for women, at clinical sites where women already seek health services. This would include recruiting female health care providers.

To improve the quality of STD services, the Project will:

- Train both the Government and private sector STD providers in a common case management philosophy which includes prompt treatment at point of first encounter with highly effective drugs on the basis of initial syndrome diagnosis, contact tracing and treatment, compliance, and confidentiality.
- Identify and upgrade the case management skills of clinicians who treat significant numbers of STD patients, high risk individuals and women. Pharmaceutical company representatives, and professional medical associations could provide access to clinicians.
- Provide targeted education about the prevention of STDs to STD patients and add promotion of and access to condoms to STD services.
- Increase access to rapid laboratory tests for diagnosis of STDs.
- Provide ongoing surveillance of etiologies for common clinical presentations and drug resistance patterns.

The APAC Project will identify and support NGOs projects that help to improve the quality of and access to STD services in Tamil Nadu. Types of NGO activities that could be funded are: 1) STD services or referral to high risk groups; 2) training government and private STD providers; and 3) supplementing the counseling, contact tracing and condom components of both governmental and non-governmental STD service facilities.

#### 4.3. Use of NGOs to Reach Target Populations

High risk groups are hard to identify, locate, and reach. NGOs have effective contact with communities at the grass roots level. They have credibility and will best be able to deliver the education, condom, and STD services which are needed by high risk groups.

APAC will fund NGO programs that provide specific high risk groups in urban and peri-urban areas of Tamil Nadu with education to promote behavior change, increase condom use, and improve the quality of and access to STD services. The activities of these NGO programs could be multi-faceted, combining elements of education, condom promotion and STD service.

The objectives of condom related activity elements are to increase knowledge about the role of condoms in disease prevention; change attitudes about condom use; increase consistent, correct condom use for every sexual encounter and ensure access to a supply of affordable condoms. STD related activity element are designed to increase health seeking behavior and access to STD services, encourage regular check-ups for STDs, reduce the social stigma attached to seeking treatment, provide STD treatment or referral services, and expand STD/AIDS counseling and education especially in low-income areas, and to women.

The Project will encourage NGOs to adopt varied and creative approaches that identify appropriate private and public access points to the target groups, develop interpersonal communication strategies, develop strategies for personal risk assessment leading to behavior change, choose and train opinion leaders and peer educators who could stimulate and support behavior change, develop interpersonal and other messages that induce change without condemning or causing guilt, develop materials for literate and low literate persons, and use a variety of media approaches to create awareness of STDs/HIV. While APAC will fund proposals for a variety of strategies that incorporate these objectives, it is important that all programs involving awareness building must be linked to the delivery of condoms and STD services.

Following are illustrative examples of NGO programs aimed at specific high risk groups. While they identify approaches and objectives which are group specific, it is again important to reiterate that they will all be linked to the delivery of condoms and STD services.

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## STRATEGIC APPROACH

**All NGO activities supported under APAC will be linked to the delivery of condoms and STD services to high risk groups.**

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### 4.3.1. Programs to Reach Prostitutes

The prevalence of HIV infection among female prostitutes in Tamil Nadu has shown a marked increase in a short time. The seroprevalence of HIV in sexworkers in Madras increased from approximately 1% in 1987 to an estimated 10% to 16% in 1991. It is critical to reach this group, who are at the highest risk for infection by and transmission of STDs, including HIV, with targeted programs.

The special objectives of activities to reach prostitutes are to reduce transmission of the virus by decreasing the incidence of STDs, improving access to STD services, encouraging regular check-ups and early treatment for sexually transmitted diseases, reducing the social stigma attached to seeking treatment for STDs, using condoms during intercourse, and developing skills in negotiating condom use.

Relatively little is known about the most effective ways to accomplish these objectives. Continuous research, evaluation and documentation of lessons learned will be critical to the success of this component of the APAC Project.

Pilot interventions begun in 1989 in Madras indicate that NGO programs should identify different categories of prostitutes and access points to these groups, establish outreach programs, and initiate education programs that will reach prostitutes through their peers, their clients, or through their pimps and procurers.

Establishing integrated outreach programs for prostitutes in urban areas outside Madras will be a priority. A recent survey of Salem, Madurai, Coimbatore, and Trichy shows that these cities have thriving commercial sex markets. The number and type of prostitutes in these areas is not known. Nevertheless, approaches used in Madras are thought to be an appropriate model as prostitution in other towns in Tamil Nadu is similarly dispersed and hard to identify.

Because the prostitute population is highly migratory, a mix of indirect strategies is likely to be needed. It has been estimated, for example, that 30 to 40% of prostitutes work in migratory brothels on 15-30 day contracts. The migratory nature of this group will pose special problems in monitoring and evaluating the effectiveness of programs for this target population.

#### 4.3.2. Programs to Reach Men with Multiple Partners

Gender-specific values related to sexual behavior are more permissive for men, who are more likely than women to experiment with casual sex and multi-partner relationships. Data indicate that transmission of the HIV virus is more efficient from men to women. Moreover, men are the primary decision makers about sexual activity and control the use of condoms. For all these reasons, it is important to reduce the spread of the infection by reaching a wide range of men who may engage in high-risk behavior at some points in their lives and then pass the infection on to their regular and casual partners.

Disaggregated, this group could be male STD clinic attenders, men in a succession of temporary alliances, male clients of prostitutes, male prostitutes and college students. As the APAC Project develops, these sub-groups are likely to be defined further by socio-economic research and analysis of epidemiological data.

An analysis of STD clinic attendance data shows that 60% of men attending STD clinics are either unemployed or employed in the informal sector, while 40% are employed in the formal sector. Outside of STD clinics, the most effective access points for employed men engaging in high risk behavior are in the occupational or work context and setting. Unemployed men must be reached at points where they congregate for recreational or other purposes. APAC will support programs that reach sexually active men at such points.

Men employed in the informal sector: STD clinic attendance data identifies as high risk groups men who have travelling, migratory, or seasonal employment: truck drivers, construction workers, three-wheeler drivers, rickshaw pullers, railway porters, port employees, travelling salesmen, and shop workers. Appropriate access points to these groups for providing services, include transport centers, such as bus terminals, railway stations, truck stops; work sites, such as construction sites; and places of congregation, such as bars and lodges (low-cost hotels used by prostitutes and their clients).

Several pilot programs in Madras are experimenting with reaching sexually active men through occupation-linked strategies as a way to target the clients of sex workers.

Men employed in the formal sector: Sixty percent of Tamil Nadu's workforce is employed in the formal industrial sector which comprises major textile, engineering automobile, and transport organizations, as well as numerous smaller companies employing between 150-200 workers. Industrial units are concentrated in the four towns of Madras, Chengalpattu, Salem, and Coimbatore. STD attendance, and sociological studies on alcoholism linking substance abuse to high risk sexual behavior, defines these areas as high risk for HIV transmission. A significant percentage of this workforce was originally migrant labor and continuing links with their areas of origin are a potential channel by which both infection and education can spread to the rural areas.

The objectives of workplace programs will be to sensitize both management and labor leaders to the need for giving AIDS prevention activities high priority; enlist support for workplace programs; gain access to the workforce for conducting programs and provide educational inputs to pre-empt discrimination against persons with AIDS. An additional objective will also be to demonstrate the viability of these programs through subsidized pilot interventions so that established activities continue independently and new ones are started after the APAC Project ends.

Specific NGO activities may include:

- Identification of model sites for demonstration projects in large and small enterprises. For each site, collaborating arrangements would be made for condom provision and referrals for STD treatment.
- Development and implementation of a training model for training of trainers.
- For smaller industries, employing less than 500 people, develop collaborative programs that provide services at a central location.

Appropriate points of access to occupational groups in the formal sector may be training colleges, worksites and union offices.

#### 4.3.3. Community Based Programs

Community based programs will be supported to reach particular groups such as low income and slum populations, who have limited access to health services, low levels of literacy and high dropout rates, and a significant percentage of informal unions (estimated for one slum as 40%-50% of the population).

Special approaches for community-based programs may include:

- Implementing discrete interventions for married and single men and women, and adolescents.
- Involving the community in identifying its own health needs, working with community leaders to create community support and involving community representatives in the design of interventions

#### 4.4. NGO Support Activities

Many NGOs will require a wide range of technical support to design and implement successful interventions (e.g., proposal development, training in counseling, media assistance.) Because many NGOs will require the same kinds of assistance, a certain amount of standardization is possible. Nevertheless, no government, private or NGO institution can offer more than one specific kind of assistance. A marketing firm, for example, can help mount a state-of-the-art advertising campaign but cannot train NGO physicians in the treatment of STDs. A university can train STD counsellors, but cannot ensure an unbroken supply of condoms to a community program. Given existing needs and capabilities around the State of Tamil Nadu, and the imperative that this Project gets in the field without waiting for the extant expertise in the Tamil Nadu to be harnessed under one institution, APAC will provide assistance from many sources to many recipients.

The PP assessments suggest that many of the grantees will require assistance to integrate APAC-supported activities into their programs. They may need training in AIDS prevention to ensure that all messages are consistent and clear and that services follow Project guidelines. They will need guidance on IEC and may also request help with the development and production of IEC materials. Introducing social marketing into grantee programs will require a significant amount of support, especially at the outset. NGOs that do not have previous experience in social marketing will need training in inventory control and financial management.

Support activities will inform NGOs about APAC, assist them in designing appropriate projects and in interacting with others working in AIDS and AIDS prevention, provide assistance in promotion, condom marketing and distribution, STD counseling, and materials development.

#### 4.4.1. Introduction, Recruitment and Networking

APAC will produce a brochure describing the purpose, objectives and priorities of the Project and articulating clearly the requirements for preparation and submission of proposals and USAID will request that the GOTN send a parallel message through official channels announcing the initiative to relevant state personnel. Regional and state-wide workshops will be organized to introduce the Project to state and district level GOTN officials, condom manufacturers and distributors, and potential collaborating organizations. Workshops for NGOs will be designed to provide opportunities for organizations to share programmatic ideas and experiences, to learn about supportive resources available through APAC, and to receive guidance on project design for service intervention and proposal preparation.

It is anticipated that at the time APAC begins, there will be a number of NGOs that have already begun or planned AIDS prevention activities. Thus, the first round of recruitment will be able to draw on them. However, once the Project is well underway it will be important for APAC to recruit actively to ensure coverage of priority programmatic and geographic areas. Identifying and assisting NGOs that have not been involved in AIDS-related work to plan activities for APAC funding may require an intensive effort.

The Project will also take a pro-active role in working with non-governmental groups to plan and organize Project activities that are not within the purview of existing NGOs. For example, APAC may work directly with small groups of private doctors, mobilizing them to train others in STD treatment regimens, or with social workers who will set up programs of counseling in conjunction with governmental STD clinics.

APAC will also encourage NGOs to share information with each other through a Project newsletter and by contributing to other AIDS bulletins in Tamil Nadu and outside the state. Also networking workshops that bring NGOs together will be very important, particularly in the first one or two years of the Project when most participating NGOs are relatively new to AIDS control work and many of the approaches are still being tested. The workshops will serve a dual purpose: they will provide training in areas of general interest that are identified either by APAC or by the NGOs themselves, and they will provide an excellent opportunity for networking and sharing valuable information.

APAC will support the development of an AIDS information center that is based in Madras with subcenters in the major cities of Tamil Nadu. There is a clear need for a resource center that will make information available to all agencies in Tamil Nadu working in AIDS prevention, as well as the general public, HIV positive individuals or persons with AIDS. Coordinated action between the GOI, the GOTN, NGOs and the private sector will require access to information about AIDS control activities in Tamil Nadu and the state of the art throughout the world.

The center will be a repository for reports, pamphlets, conference proceedings, journals, books and IEC materials. It will have reports of APAC-supported activities and research studies, unpublished and published papers from other organizations in Tamil Nadu and throughout India, lists of resources in the social, preventive, epidemiological, medical and legal aspects of AIDS, and information about available funding sources. The center will collect materials internationally from organizations such as WHO/GPA, AIDSCAP, the UK NGO AIDS Consortium, the AIDS School Education Resource Center of UNESCO, and subscribe to national and international journals.

In order to ensure the sustainability of the resource center, it will be organized in collaboration with an existing organization. Possible agencies that would be appropriate include nodal NGOs like the Voluntary Health Association of India (VHAI) which has a large membership of voluntary organizations throughout Tamil Nadu and already plays the role of disseminating health related information to its members. Other possibilities would be university schools of information technology or library sciences, Chambers of Commerce, and the Public Library network of Tamil Nadu. Whichever agency is chosen, training will be required to inculcate a pro-active information gathering and dissemination attitude. The center may recover operating costs by charging fees for membership and ad hoc services.

#### 4.4.2. STD Counseling Module

As counseling of male and female STD patients in Tamil Nadu is virtually nonexistent, APAC will need to support a major effort to train all levels of health workers and community-based NGO workers. STD clinics have social workers who represent an avenue for providing advice, but they are not trained in the counseling techniques to support behavior change (such as personal risk assessment, AIDS and STD education, motivation to support compliance with treatment or regular check-ups).

The Christian Medical College (CMC) in Vellore is in the process of developing a series of modules for counselor training, focusing primarily on counseling for HIV positive persons and their families. CMC is currently carrying out a counseling program for these groups, has designed supporting educational materials, and has also developed training of trainer modules for HIV/AIDS education. The opportunity exists to work with CMC to adapt this approach for application to counseling of STD patients.

The content of the modules will include STD and HIV disease prevention, contact tracing, compliance with treatment regimens, the provision of social and psychological support, and skills in condom use. There also needs to be a component of the module that deals specifically with counseling of STD patients who are HIV positive.

#### 4.4.3. Interpersonal Communication Materials

Selected pre-tested, educational materials are needed to support the interpersonal IEC activities planned in the APAC Project. These core materials will be designed to complement the national AIDS awareness campaign. They will incorporate consistent, non-judgmental, culturally specific messages that will be used and adapted, as appropriate, by NGOs. Since APAC plans to implement the Project by involving a broad spectrum of NGOs, many of which are unfamiliar with STD/HIV issues and messages, it is important to ensure that good materials are available to these groups.

Coordination by APAC of the production of core materials will prevent unnecessary duplication of the time consuming and costly processes of pretesting and producing materials. APAC will identify organizations that will develop the prototypes and make copies, as needed. A number of organizations in Tamil Nadu have a proven capability in the development of effective interpersonal communication aides, although not all have experience in the area of STD/HIV prevention. These include the Tamil Nadu Integrated Nutrition Project (TINP), local advertising agencies and NGOs.

Materials will be prepared to address different levels of audience (e.g., trainers of trainers, community organizers or health educators, and the primary target audience); different types of audiences (e.g., prostitutes, men in workplace, women, low literates); and different kinds of activity (e.g., counseling in STD clinics, STD/HIV community education, and support for discussion groups.)

A needs assessment and analysis of planned activities among NGOs submitting proposals for APAC funding will provide guidance as to which materials will be most valuable in the first years of the Project. These needs should be reassessed on a regular basis by the Project review committee, meeting together with NGO representatives. As the Project develops, NGOs are also likely to develop some materials of their own: collaboration among NGOs to avoid duplication in materials production will be encouraged.

While initially, the APAC Project will coordinate the development, production and dissemination of the IEC materials, gradually, the organizations that are responsible for producing the materials will take on more responsibility for their distribution, covering their costs by charging for services. It is expected that IEC support to NGOs working in AIDS prevention activities will be self-sustaining by the end of the Project.

#### 4.4.4. Distribution of Condoms

In 1991 ITC<sup>5</sup> sold approximately 15 million condoms in Tamil Nadu through its social marketing program, London Rubber sold an estimated 10 million commercially, and some 21 million free condoms were distributed through government programs. APAC will work with condom distributors, supporting the strengthening and expansion of these distribution systems to increase sales of condoms to high risk groups. Of the 100,000 potential retail outlets in Tamil Nadu, presently there is adequate distribution to approximately 50,000. Distribution of socially marketed condoms by ITC is widespread throughout Tamil Nadu in both traditional and non-traditional channels, including approximately 10,000 outlets in Greater Madras alone. Although TTK Pharma sold 40% of the condoms that were sold in Tamil Nadu in 1991, their network is more limited, mainly including chemist shops and the larger general stores.

The APAC Project will be encouraging ITC and private distributors to sustain an uninterrupted flow of condoms through these existing distribution systems and to take on some new channels of distribution. ITC has already expressed a willingness to expand its distribution to serve the NGOs working under the APAC Project and to provide technical assistance, helping them to set up and maintain inventory control and financial management systems. It will be important to assure that a steady supply of condoms reaches government STD clinics, other public health delivery posts, and the various workplace programs initiated under the APAC Project.

The Project will also act as a conduit between commercial marketers and a variety of NGOs that could facilitate opening new commercial sales outlets to serve high risk groups, including private hospitals, blood banks and private practitioners, associations of employers, trade unions, government agencies, and possibly university administrations or student associations.

#### 4.4.5. Promotion of Condoms

Funds will be allocated for a mass media component primarily aimed at condom promotion, in order to reinforce the messages conveyed by interpersonal communication and educational materials about condoms and to demonstrate the benefits of effective promotion and marketing to condom distributors in the state. In collaboration with an advertising agency, condom manufacturers, social marketing agencies, and the GOTN, a campaign plan will be developed to target sexually active men and women through the mass media, using radio, TV, press, and cinema.

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<sup>5</sup>ITC was formerly called the Indian Tobacco Company, however the firm's official name is now ITC.

APAC will coordinate the campaign, providing a major portion of the funding during the first two years, in cooperation with condom distributors and the GOTN. Gradually, as APAC-supported condom promotion and distribution efforts begin to show results and sales increase, the commercial sector will assume a greater share of the advertising costs.

The campaign need not be brand specific but can take the form of generic condom promotion. The objectives will be to change social norms about condoms in order to make them more acceptable and to complement the current link of condoms with family planning by fostering the concept of condoms for disease prevention. Campaign approaches that seek to link condom use with a socially desirable image may be the most successful.<sup>6</sup>

Campaign strategies will be developed that reflect audience preferences and viewing patterns in Tamil Nadu. The importance of cinema in the state is well known, with its greatest reach being to lower income populations. A recent audience study showed that between 67% to 75% of those with a monthly income below 2,000 rupees were regular cinema attenders. In an earlier study of 2,000 STD patients, 70% gave "cinema going" as their major leisure activity. Radio and TV are also popular media, although television is more popular among higher income groups. Campaign planning will also need to consider current restrictions on condom advertising or program sponsorship.

PP design meetings with media representatives indicate that additional reinforcement for HIV/AIDS messages can be provided through encouraging coverage of AIDS-related stories in the English and Tamil local press, in order to reach both opinion leaders, including the print media, and the general public.

#### 4.5. Research

Research will be integral to ensuring that the most effective strategies for achieving APAC Project targets are employed: research findings will be used to design and modify approaches to HIV prevention. NGOs will be encouraged and assisted to use rapid assessments or formative research prior to launching activities to provide information essential to planning appropriate approaches. Behavioral research will be undertaken to study knowledge, perceptions and sexual practices that affect the way populations could protect themselves from HIV infection, and operational research will be used to ascertain the relative cost effectiveness and sustainability of various interventions.

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<sup>6</sup>The non-brand specific "Condoms Because You Care" campaign in the Eastern Caribbean, for example, which implicitly associated condoms with a positive lifestyle rather than pushing a factual message, contributed to an 83% increase in average monthly condom sales following campaign implementation.

The Project will commission reviews of extant research, particularly in the areas of behavioral and operational research, to identify gaps in knowledge, and to outline priorities for interventions, and for additional research. An independent research committee will be set up to advise the Project on protocols generated by local researchers, ensure that appropriate clearances are obtained, and establish a regular process of reviewing all research findings and disseminating results for application to the design and implementation of APAC Project activities.

APAC expects to undertake at least 15 behavioral or operational research studies in support of project objectives. Various types of organizations will be involved, depending on the nature of the skills required, including: NGOs carrying out pilot projects, schools of social work, other academic institutions, consulting firms specializing in research, and advertising and market research agencies, as well as individual researchers. APAC will provide technical assistance to these institutions and periodic workshops will be held for the purpose of bringing together researchers to prepare study designs, research protocols and data analysis and to present results.<sup>7</sup>

It is expected that APAC's research studies will use a range of quantitative and qualitative methodologies such as participant observation, focus groups, in-depth personal interviews with key informants for in-depth ethnographic approaches, structured questionnaires for sample projects, and extant clinical and laboratory data. Examples of research topics include:

- Ethnographic studies to identify factors that characterize high-risk or low-risk behavior.
- Investigating the motivations of current condom users and non users (for family planning as well as disease prevention) to identify reasons for using or not using condoms.
- Investigation of health care seeking behavior for STD diagnosis and treatment including motivations and barriers to seek treatment, and who provides advice and treatment of STDs for different population sub-groups.

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<sup>7</sup>Organizations participating in the project that do not already have a research review committees will be encouraged to establish one to ensure that research protocols are observed, including provisions concerning the rights of human subjects, such as confidentiality and informed consent.

- Assessing the cost-effectiveness of methodologies and personnel structures for delivering AIDS prevention services such as STD treatment, counseling, community outreach, condom distribution by NGOs, contact tracing and materials development.
- Audience impact studies to assess short- and long-term retention of education conveyed through different forms of media.
- Research to assess the validity of syndrome based treatment, and different methods for determining STD rates in men, (utilizing either laboratory based screening or self reported histories of STD symptoms).
- Assessing the impact and cost-effectiveness of Project prevention interventions.

Because the epidemic is still in the early stage, there is also a need to monitor the selection of target audiences and add to them in the light of emerging information from HIV prevalence data and behavioral research. Some groups have already been identified as possible targets for interventions, but little specific information exists about their degree of risk or role as core transmitters. Research is needed, for example, on HIV rates among intravenous drug users, and the sexual behaviors and population size of such groups as men who have sex with men and out of school youth. Tribal populations which demonstrate high prevalence of STDs may also be identified as a target group.

## 5. MEASURING PERFORMANCE

### 5.1. Evaluation

Overall project evaluation will focus on four outcome indicators. The first three indicators are being refined by WHO for use as part of a set of Global Priority Prevention Indicators (PPIs). These will be incorporated into AIDS/HIV prevention projects around the world by both USAID and the WHO Global Program on AIDS. The fourth is a direct measure of a USAID/India objective to increase the private provision of health and family planning services. The indicators are increased sales of condoms, improved quality of STD services, increased knowledge of protective measures against HIV/STD transmission, and an increase in the number of NGOs involved in AIDS/STD prevention activities.

These indicators will be measured periodically over the life of the Project: the expansion of NGO activities will be assessed at least once a year; the qualitative indicators, improved quality of STD services and knowledge of HIV/STD prevention, will be measured every two to three years, in conjunction with midterm and final Project evaluations; condom sales, which is a process indicator as well as a measure of overall Project performance, will be monitored monthly.

Different methodologies will be employed to measure each indicator at intervals during the Project and at the end of the Project. Local institutions will be identified to design and conduct the research. The approach to measuring the four indicators will be as follows:

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#### OUTCOME INDICATORS

- **increased sales of condoms**
  - **improved quality of STD services**
  - **increased knowledge of protective measures against HIV/STD transmission**
  - **an increase in the number of NGOs involved in AIDS/STD prevention activities.**
- 

**Condom sales** data will be obtained through monthly reports of retail distribution from distributors.

**Quality of STD services** will be measured using facility-based observational methods using three indirect indicators twice during the Project and at completion:

- **Treatment** -- Number of persons with a defined symptomatic STD (Urethritis in men or genital ulcer disease in men and women) seeking treatment who were assessed and treated using established guidelines.
- **Condoms** -- Number of persons with a defined symptomatic STD seeking treatment who received condoms.
- **Partner Notification** -- Number of persons with a defined symptomatic STD seeking treatment who received advice on partner notification.

**Knowledge of preventive practices**, not a sensitive indicator in the short run, will be measured every two or three years, and at the end of the Project. The methodology will be to draw a community-based random sample of men and women, between 15 and 34 years of age, who will be asked to cite at least two ways by which they can protect themselves from acquiring HIV.

In addition, specific IEC interventions will be measured periodically using rapid surveys that draw samples from high risk populations targeted by the Project (e.g., prostitutes, lorry drivers or slum dwellers.)

**NGOS involved in STD/HIV prevention activities** will be measured by monitoring grant requests and other Project funded activities.

## 5.2. Evaluation Cycle

The first evaluation of the Project will take place at the beginning of the third year. An early evaluation is warranted for several reasons. The epidemic is in an early phase and changes may occur both in the epidemiology and the response of the community that would mandate reorientation of the approach, including redefinition of the target groups or the IEC strategy. Secondly, the methodologies for reducing transmission of HIV/STDs are still being tested and the first two years of the APAC Project should be considered experimental.

The first evaluation will analyze progress toward achieving project indicators and identify elements of project design, management and implementation that helped or hindered success. The evaluation team will likely include representation from the GOI, the GOTN and AIDSCAP. At a minimum, the team will be composed of specialists in STDs, IEC, research and condom distribution. The team should include individuals with experience evaluating AIDS control projects worldwide who can offer a broad perspective.

It is anticipated that the second evaluation will take place during the fifth year. The primary focus of the second evaluation will be an assessment of lessons learned that can be applied to the planning of future activities and sustaining Project funded activities.

## 5.3. Monitoring

**Project monitoring will focus on process indicators** that will help to assess the performance and, to the extent possible, effectiveness, of individual Project-supported activities. It will be critical to select indicators that are useful to project and sub-project managers but that do not divert Project personnel from direct services.

Selection should be a process of weighing the relative sensitivity of an indicator as a measure of performance, the accuracy with which it can be reported, and the demands on the NGO staff to collect and report the information.

Every NGO grant will identify at least two process indicators that will be reported on twice a year. Indicators will vary according to the type of activity. For most NGO grants quantitative indicators can be identified that will meet the selection criteria. Some grants will also need to use qualitative indicators for monitoring. For example, a grant that is producing communication materials or promoting condoms will need to measure knowledge, attitudes and/or behavior on a regular basis.

Following, is an illustrative list of quantitative process indicators, by type of activity.

Community-based activities that are designed to reach high risk groups with education and distribution of condoms:

- number of educators trained
- number of training sessions held
- number of education programs/ performances held
- number of people trained/ attending education programs/ performances
- number and types of communication materials development
- number of condoms distributed

Workplace-based activities:

- number of training sessions held for management, union leaders, employees
- number of employees and management personnel participating in HIV prevention activities
- number of work sites participating
- number of condoms sold

STD services activities:

- number of providers trained in STD case management, counseling
- number of sites providing standardized STD treatment, counseling
- number of male patients, female patients
- number of persons contacted through outreach activities
- number of condoms distributed

#### Condom distribution activities:

- number of condoms sold, by month
- number and type of outlets, by month

The grantees will prepare and submit brief reports every six months that will be used by the NGOs for internal review and by APAC for tracking. Aside from reporting on process indicators, the reports will provide the opportunity to cite highlights as well as barriers encountered. Regular visits, at least twice a year, by APAC staff will be a critical element of the monitoring process. Project staff will use these visits to provide constructive support and advice, as appropriate, and to learn more about approaches that appear to be working. APAC will follow up with any NGO that identifies a need for further assistance.

## 6. IMPLEMENTATION PLAN

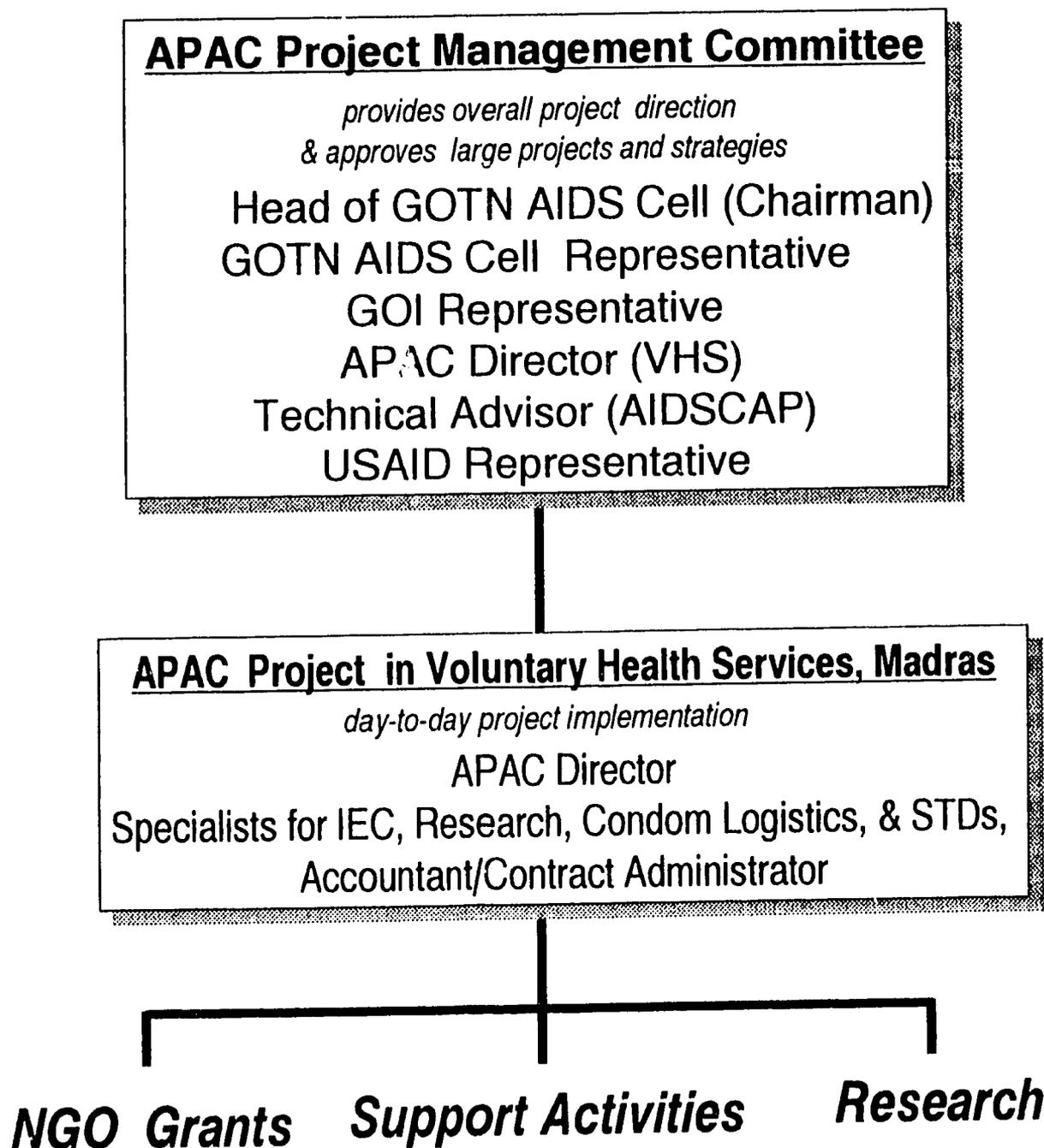
### 6.1. Project Organization and Implementation

#### 6.1.1. Project Administration

Figure 6.1 represents the Project Management plan for APAC. Overall project direction will be provided by a Project Management Committee. This committee will be chaired by the head of the GOTN AIDS Cell (or appropriate designate of the GOTN's Secretary of Health and Family Welfare). Its members will include a second representative from the Tamil Nadu AIDS Cell or GOTN designate, the USAID Project Officer, the APAC Director from Voluntary Health Services (VHS) in Madras, the technical advisor to the Project from the RD/H/AIDS worldwide AIDSCAP Project and, possibly, a representative of the GOI MOHFW.

After what is expected to begin as a series of monthly meetings, this committee will settle into a quarterly meeting schedule to review and sanction large NGO grants and APAC strategies for support and research activities. The committee will also be responsible for monitoring the Project's financial plans, program progress, consultant requirements, and reviewing APAC Project activities for consistency with national and state policy.

# PROJECT MANAGEMENT



Day-to-day technical and financial management of the Project will be the responsibility of VHS. VHS will establish and staff an autonomous APAC unit within its existing administrative structure. Under the technical direction of the Project Management Committee, this unit will establish guidelines for implementing each of the components, identify, select and fund organizations and individuals carrying out APAC-supported activities, and ensure the technical integrity of these activities. Its duties will include the appraisal of all Project grant requests and seek the recommendations of the PMC, the sanctioning of small grants (\$6,000 and less), and the development of NGO support and research strategies. The unit will represent the Project in the NGO community and with the government.

A key determinant to the success of APAC will be how well project interventions are developed and targeted, and how effectively a wide range of support can be provided to NGOs. To ensure quality results, the Project will rely on a strong staff. VHS will have a core staff that includes the APAC Director, and specialists for IEC, Research, condom logistics, and STDs, and an accountant. Position descriptions are as follows:

The **APAC Director** will have overall responsibility for the technical and financial management of the Project. Specific responsibilities include:

- coordinating with the PMC, GOI, GOTN, VHS, AIDSCAP, and USAID and other donors
- serving as a member of the PMC
- developing a project tracking systems and reporting as required to the PMC to facilitate the Committee's role in project direction and monitoring,
- submitting semi-annual program and quarterly financial reports to USAID
- public relations/ press relations
- recruiting project staff, as needed
- preparing annual work plans, including NGO support and research strategies
- recruiting technical consultants, as required, via contracts and grants
- obtaining inputs from IEC, research, logistics and STD technical advisors on NGO proposals to submit to the PMC
- overseeing or leading project appraisals, peer review of proposals, project monitoring teams, evaluations

The **IEC Specialist** will be responsible for coordinating all IEC and promotional activities supported by the Project. Specific responsibilities include:

- coordinating with the GOTN, GOI, other donors in the area of IEC
- ensuring that messages use under APAC supported activities are culturally sensitive, consistent and coherent
- monitoring the quality of all IEC materials
- monitoring all pre- and post-testing of messages and materials

- ensuring APAC IEC activities complement and do not duplicate other IEC activities in Tamil Nadu
- briefing NGOs on the development of IEC activities and materials
- recruiting and coordinating technical assistance responsible for materials development and production (contracts and grants)
- coordinating the mass media campaign for promoting condom use and STD case management
- coordinating of training in materials development
- monitoring the activities of the AIDS information center(s)

The **Research Specialist** will be responsible for coordinating all research and evaluation activities in conjunction with APAC. Specific responsibilities include:

- coordinating with the GOTN, GOI, other donors, and AIDSCAP in the area of research
- developing of a research agenda for APAC that covers project requirements in formative research, behavioral research, operations research and evaluation research
- convening an research committee to that will advise the Project on the development and participate in the monitoring of the research agenda
- determining the scope for research in NGO submitted grant proposals
- monitoring research activities
- providing technical assistance to NGO grantees in the design, implementation and interpretation of research
- recruiting and coordinating other technical assistance, as needed, for the design, implementation, and/or dissemination and application of research
- disseminating research results
- developing a pool of individuals and institutions that would be a resource for research
- monitoring the application of research results

The **Condom Logistics Specialist** will be responsible for ensuring that the condom distribution system within APAC functions smoothly. Specific responsibilities include:

- coordinating with condom manufacturers, GOI social marketing agencies and GOTN MOHFW representatives
- ensuring the continuous supply of condoms to all participating NGOs
- monitoring NGO inventory and control systems
- coordinating the collection and analysis of condom sales and distribution data
- coordinating retail audits and other studies to evaluate condom distribution and sales systems
- coordinating training activities associated with condom distribution by NGOs

- providing training and technical assistance to NGOs in the areas of inventory management and control, including MIS
- coordinating participation of condom manufacturers, and social marketing groups in the condom promotion campaign

The **STD Specialist** will be responsible for coordinating all STD activities supported by APAC. Specific responsibilities include:

- coordinating with the GOTN, GOI, WHO, and AIDSCAP in the area of STD prevention and services
- collaborating with GOTN institutions, monitoring the development of standard treatment regimens for India, particularly syndrome management approaches
- coordinating APAC activities relating to the quality and expansion of STD services, including training in case management that addresses counseling, contract tracing, condom promotion, continuity and confidentiality
- collaborating with the NGO and for-profit sectors involved in STD service delivery, research and/or training
- monitoring behavioral research relating to STD prevention and treatment
- providing technical assistance to STD service delivery points

The **Accountant/Contract Administrator** will be responsible for the financial management of the APAC operating budget and the grants and services contracts. Specific responsibilities include:

- establishing of APAC checking account and accounting for revenue. (Checks will be signed by a person other than the accountant.)
- budgeting, accounting, disbursement, and review of all APAC operating expenses
- administrating contracts with bank or accounting firm and service contractors
- preparing quarterly financial reports for USAID
- coordinating pre-audit financial reviews of NGOs
- disbursing advances and quarterly funds to NGOs and other grant recipients
- monitoring and reviewing grant and service contract invoices and expenditures
- coordinating of final audits of NGOs and other grant recipients

The Project will also call on consultants to appraise, monitor and evaluate project activities, as well as to provide specific technical assistance as required. Consultants for appraisals and monitoring will include state and district level officials in the health, social welfare and social defense sectors so as to benefit from GOTN experience and to ensure coordination with Government programs. Any consultancy services provided by government officials will follow the 1988 A.I.D. guidance on Supplementary Payments.

The RD/H/AIDS worldwide AIDS Control and Prevention (AIDSCAP) Project (PDE-5972-A-00-1031) will provide a Resident Advisor for India who will be linked to the APAC Project as a consultant to VHS. This person will provide technical and programmatic advice to the APAC Office and will sit on the PMC to advise it from an international information base. S/he will assist the Project to take advantage of the AIDSCAP program in areas such as international consultancies in STD research and case management, communication, training in counseling and research, reporting on state-of-the-art research on AIDS and AIDS prevention interventions and technologies, and international study and networking opportunities.

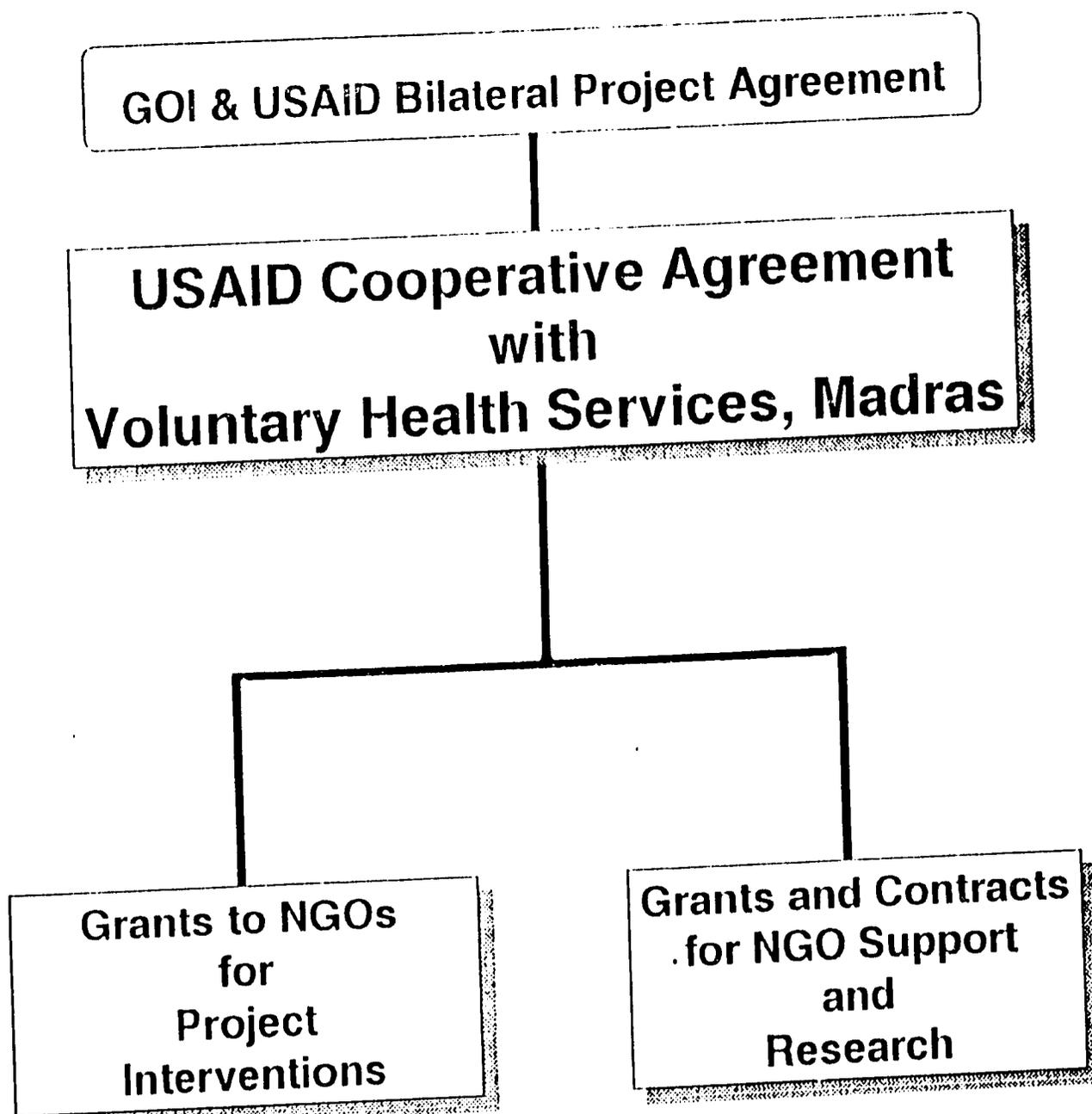
#### 6.1.2. Contracting Plan

Figure 6.2 represents the contracting plan for APAC. It is a two-tiered plan, minimizing the management burden on USAID while maximizing USAID's control of Project resources.

The **first tier** of the contracting plan calls for USAID to enter into a **Cooperative Agreement with the Voluntary Health Services (VHS)** in Madras for approximately \$10 million for seven years. This agreement with VHS, justified in accordance with A.I.D. Handbook 13, Chapter 2, will support the hiring of the APAC technical specialists and support staff. VHS will contract with an accounting firm to complete pre-grant audits of institutions under consideration for funding, and with a bank or accounting firm to manage the disbursements of the NGO grant, and other funds, and with a management consulting firm to subcontract for NGO support activities, and research elements of the Project.

A key element of this contracting plan is that, by using VHS for day-to-day implementation of work directed by the PMC, Project funds will not flow through the GOI budget, but instead be granted directly to an organization in India. This will shorten the response time needed for NGO grant approval and the disbursement of funds to local NGO's. Given the devastation AIDS can have on individuals, communities, and the health care system, the ability to respond quickly is imperative.

## CONTRACTING PLAN



VHS was chosen for this role during a comprehensive review of potential governmental, international and private project implementation options. VHS is a large, reputable health care NGO situated in Madras that has been operating since 1958. The institution has worked well with the GOI, GOTN and USAID. It runs a 300 bed hospital, has 340 Full-Time Equivalents (FTEs), 40 part-time staff and numerous volunteers. It is sustained through donor funds, private donations and some fee-for-service activities. (Annex K contains a recent VHS Annual Report.)

VHS is interested in implementing the APAC Project. The organization holds a Foreign Currency Registration (FRC) certification which enables it to receive foreign assistance funds and to subgrant them to other NGOs. It is believed that VHS will be an acceptable option to the GOI and GOTN and a preliminary review indicated that the organization's commitment to community health services raises promise that VHS would be able to continue parts of the APAC NGO program beyond the life of the Project. VHS will likely contract for the accounting and banking expertise needed to complete audits and other administrative matters, and will create, as it has in the past, a separate APAC Project cell within its organization to ensure autonomy and technical focus of Project activities. A capabilities assessment of VHS has been conducted by the USAID Controller's office and a number of changes are recommended to insure the APAC unit of VHS meets USAID accounting and reporting standards. The major findings are listed in Annex J.

**The second tier of the Contracting Plan consists of grants, service contracts and other appropriate assistance instruments to be used by VHS to fund APAC NGO Grants, Support Activities and Research.**

On the approval of the PMC, VHS will award grants, using a generic grant agreement format. (See Annex J5 for a form that has the approval of the USAID Regional Contracting Officer.) VHS will provide advances to the grantees and report to USAID on project expenditures and commitments.

Service contracts, or some other appropriate assistance instrument, will be used if a firm is required to provide technical services, ranging from publicity campaigns and market surveys to pre-audits of institutions, accounting, disbursement of funds and audits. It is expected that each contractor would provide services to several NGO grantees. A standard VHS or USAID contract format will be adapted for use under the APAC Project. VHS will enter into a service contract once the PMC has approved a contract plan, either as a specific contract or as part of a strategy.

### 6.1.3. Grant Selection Process

APAC will give the highest priority to supporting cost effective HIV and STD prevention and control activities directed to the highest risk populations throughout Tamil Nadu. As better information becomes available about the progression of the epidemic and the relative effectiveness of strategies, the priorities will shift accordingly.

To assure flexibility of approach without causing an undue management burden on project staff, grants will be given for a maximum of three years, with the possibility of extension. All grants will be clearly focused on the APAC strategy: APAC funding will be used exclusively to support activities directly related to the Project. Grants may vary from small pilot community-based activities to large projects that cover several parts of Tamil Nadu. An estimate of the range of proposal budgets envisioned appears in Section 7.2.

The awarding of grants will be a two-stage process: Sub-projects will be selected on the basis of a technical review of the proposal with final approval dependent on a satisfactory evaluation of the financial management and administrative capability of the organization.

Criteria for selection: Selection will take into consideration the following: (a) the activity targets one of the designated high risk or vulnerable population groups; (b) the approach is designed to reach the target population and either has been tested, or sound formative research is planned; (c) a significant number of people will be reached; (d) the budget is reasonable relative to the number of beneficiaries; (e) the activities complement but do not duplicate those of other organizations operating in the same geographic area; (f) the applicant has the administrative capability to carry out the Project; (g) the requisite technical capacity is present within the existing staff or an acceptable plan for adding staff is presented; and (h) the organization is currently involved in social marketing of condoms or is willing to participate in social marketing.

Grant review: There will be a minimum of four funding cycles each year.<sup>8</sup> Deadlines for submission of proposals will be announced at least three months in advance. The APAC Director will be responsible for convening appropriate peer review of proposals.

It is anticipated that most NGOs will have had at least some interaction with APAC staff during the proposal development stage, and that their proposals, therefore, will fulfil most of the basic requirements. However, the technical review process should be flexible and, when appropriate, iterative, providing an opportunity for APAC to give constructive support to NGOs in the design of their projects. There will be a standardized format for all proposals.

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<sup>8</sup>This schedule will be reviewed during the first year of the project.

Pre-award evaluation of potential grantees: There will be evaluations of all organizations under consideration for grants or service contracts to verify that they have the capability to carry out the agreed upon program and achieve the objectives articulated in their proposal. They also will have to have adequate accounting and financial systems to track USAID funds and to report accurately on those funds.

Annex J6 contains a simple five page checklist called "Adequacy of Accounting and Reporting System" which can be used to ascertain the capability of the grantee to account for USAID funds. It specifies such financial management tools as cash receipt journals, general ledgers, separate checking account for USAID funds, periodic reconciliations of bank statements, etc. If some of these things do not exist, the evaluator can suggest ways in which they can be established to help improve and institutionalize the financial management system of the NGO. In the case of small, one-time grants in amounts of less than \$1,000, the pre-audit evaluation will require only a simple, basic accounting mechanism.

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## PROPOSAL ELEMENTS

**Objectives:** Expected achievements will be clearly articulated, preferably some quantitative, measurable objectives. This section will include a description of the target group to be reached, the approach, and justification for the plan vis-a-vis the needs of the group targeted.

**Scope of work:** The applicant will describe the plan of action for implementation, specifying the activities that will be carried out and a detailed schedule.

**Formative research:** (Optional) Some organizations that will identify formative research as a key element in their scopes of work, while others may require assistance from APAC in this area.

**Monitoring plan:** Every project must identify at least two key process indicators by which to measure progress.

**Management plan:** To include a description personnel, the financial management plan, and the name of the organization that providing financial auditing services to the NGO.

**Budget:** To be presented by standardized line items by year.

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Any grantee receiving more than \$25,000 per annum from USAID will be required to undergo evaluations of its financial systems and more extensive audits of its books. These audits will be the responsibility of VHS. The USAID controller's office will provide more detailed instructions when the need occurs.

## 6.2. Implementation Schedule

Project implementation will be tracked through the use of annual plans, with semiannual reports providing the mainstay of program documentation. The first annual plan will be drafted and reviewed by the PMC in Month 2. The following is an illustrative breakout of Project benchmarks for Year 1.

Month 1	Project Management Committee (PMC) appointed Agreement signed with VHS APAC Director recruited Accountant recruited Madras office equipped Financial management systems established Preparation of program announcement
Month 2	Remaining APAC staff recruited Annual work plan drafted First meeting of the PMC and formal Project announcement Introductory workshops held for relevant NGOs, condom manufacturers, and GOTN officials Condom sales baseline data established
Month 3	First NGO grant awarded and support activities commence Research agenda prepared
Month 4	Knowledge, Attitude and Practice (KAP) baseline information gathered
Month 5	STD counseling module completed
Month 6	Semi annual report prepared Research Studies begin Resource Center established
Month 8	Condom advertising campaign launched
Month 12	Annual work plan developed Semi annual report prepared

### 6.3. USAID Management

The USAID Office of Population, Health and Nutrition will have primary responsibility for managing the APAC Project and will designate a staff member as the USAID Project Officer for APAC. This Officer will work with the APAC Director, VHS, the Government of India, and the Tamil Nadu Government to promote project objectives, monitor project progress, anticipate potential problems and identify project opportunities.

The Project Officer will serve as a member of the PMC, will participate in appraisal of grant proposals, and make site visits to monitor Project activities on a selective basis. S/he will be responsible for organizing and conducting a midterm and final evaluation of the Project.

### 6.4. Project Monitoring Plan

The USAID Project Officer will monitor the Project closely. S/he will receive quarterly financial reports and semi-annual program reports from the APAC Project. The semi-annual reports will be submitted by the APAC Director in March and August to coincide with the USAID mission's semi-annual PIR. The reports will track progress towards meeting the End-of-Project Status indicators and host country contributions. In addition, s/he will meet regularly with the APAC Project Director and visit Project sites.

Through VHS, the PMC, will monitor strategic planning and evaluation, the selection of APAC grantees and contractors, and financial management. The APAC Director will prepare relevant background papers to the PMC to facilitate its monitoring role.

The APAC Director will be responsible for day-to-day monitoring of Project operations. S/he will ensure that the APAC staff track the implementation of all Project activities. The technical staff will monitor all grants and contracts to determine the extent to which they are conforming to the proposals and agreements on which their funding is based. The accountant will monitor the disbursement of funds and the accountability by the recipients for those funds.

## 7. ESTIMATED BUDGET and BUDGET ANALYSIS

### 7.1. Estimated Budget

The estimated total cost of the Project over its seven-year life is \$17 million, including inflation. Of this, A.I.D. will provide \$10 million and the host country \$7 million (in condoms).

Table 7.1 illustrates Project costs to be covered by USAID by specific Project elements.

TABLE 7.1

#### SUMMARY OF PROJECT BUDGET

	<u>Amount (\$ in 000s)</u>	<u>% of total</u>
Administration	1,326	13.3%
NGO Grants	4,300	43.0%
NGO Support & Dev.	3,666	36.7%
Research	368	3.6%
Evaluation & Audits	340	3.4%
	<hr/>	<hr/>
	10,000	100%

Detailed estimates of the budget by total, base and inflation costs is shown by year in Table 7.2.

The budget estimate for A.I.D.'s contribution includes inflation of \$1.53 million. The financial plan assumes a 12% inflation on rupee costs of "Administration" and "NGO Support & Development" line items of the budget. An exception has been made for rental cost which has been budgeted at the rate of Rs.10 per sq.ft. per month for 5,000 sq. ft. and is assumed to be fixed during the normal lease period of three years. Thereafter, it is incremented by 15% in Year 4 and Year 7 keeping each lease period cycle constant at three years. It should be noted that the estimate provides for inflation in the case of local currency costs ignoring the probable devaluation of rupee parity rate vis-a-vis US dollar as the exchange rate regime has been liberalized from an administratively determined rate to a rate determined by market forces. Since it is not possible to extend the historical perspective of the exchange rate determination to future transactions, inflation is assumed on rupee costs. An inflation factor of 5% has been assumed on foreign exchange costs.

TABLE 7.2.

## AIDS PREVENTION AND CONTROL PROJECT (386-0525)

EX. RATE (\$1 =)  
30 Rupees

## ILLUSTRATIVE SUMMARY OF PROJECT BUDGET (fig. in '000)

	COST CATEGORY	YEAR 1		YEAR 2		YEAR 3		YEAR 4		YEAR 5		YEAR 6		YEAR 7		GRAND TOTAL	
		Rs.	\$	Rs.	\$												
	<b>Total Cost</b>																
1.	<b>ADMINISTRATION</b>																
A.	Prof. Salary & Benefits	1,060	35	1,187	40	1,330	44	1,489	50	1,668	56	1,868	62	2,092	70	10,694	356
B.	Support Staff Sal & Benefits	138	5	154	5	173	6	194	6	217	7	243	8	272	9	1,390	46
C.	Domestic Travel	138	5	154	5	173	6	194	6	217	7	340	11	381	13	1,596	53
D.*	International Travel		18		19		20		24		25		26		27		160
E.	Communications & Utilities	265	9	297	10	332	11	372	12	417	14	467	16	523	17	2,674	89
F.	Start-Up Costs and Office Expense	918	31	956	32	999	33	1,181	39	1,250	42	1,323	44	1,634	54	8,266	276
G.	Equipment - Capital	1,431	48			665	22			834	28					2,930	98
H.	Vehicle - Rental	413	14	463	15	691	23	774	26	1,084	36	1,214	40	1,088	36	5,729	191
I.	Contractual Services	212	7	178	6	199	7	223	7	250	8	280	9	314	10	1,657	55
	<b>SUB-TOTAL.</b>	<b>4,575</b>	<b>171</b>	<b>3,390</b>	<b>132</b>	<b>4,562</b>	<b>172</b>	<b>4,427</b>	<b>171</b>	<b>5,937</b>	<b>223</b>	<b>5,741</b>	<b>218</b>	<b>6,303</b>	<b>238</b>	<b>34,936</b>	<b>1,325</b>
2.	<b>NGO GRANTS</b>	<b>12,000</b>	<b>400</b>	<b>19,500</b>	<b>650</b>	<b>123,000</b>	<b>4,300</b>										
3.	<b>NGO SUPPORT &amp; DEVELOPMT.</b>																
A.	IEC	1,696	57	2,968	99	3,324	111	3,723	124	2,669	89	2,989	100	1,674	56	19,043	635
B.	STD Counselling	276	9	370	12	415	14	465	15	347	12	389	13	435	15	2,696	90
C.	Promotion of Condoms	3,604	120	12,347	412	13,829	461	12,361	412	10,341	345	7,846	262	4,394	146	64,721	2,157
D.	Coordination	2,332	78	2,612	87	2,925	98	3,276	109	3,669	122	4,110	137	4,603	153	23,528	784
	<b>SUB-TOTAL.</b>	<b>7,908</b>	<b>264</b>	<b>18,297</b>	<b>610</b>	<b>20,493</b>	<b>683</b>	<b>19,825</b>	<b>661</b>	<b>17,026</b>	<b>568</b>	<b>15,333</b>	<b>511</b>	<b>11,106</b>	<b>370</b>	<b>109,987</b>	<b>3,666</b>
4.	<b>RESEARCH</b>	<b>1,500</b>	<b>50</b>	<b>2,300</b>	<b>77</b>	<b>2,300</b>	<b>77</b>	<b>2,300</b>	<b>77</b>	<b>1,500</b>	<b>50</b>	<b>750</b>	<b>25</b>	<b>400</b>	<b>13</b>	<b>11,050</b>	<b>368</b>
5.**	<b>EVALUATION &amp; AUDITS</b>	<b>600</b>	<b>20</b>	<b>600</b>	<b>20</b>	<b>600</b>	<b>120</b>	<b>600</b>	<b>20</b>	<b>600</b>	<b>120</b>	<b>600</b>	<b>20</b>	<b>600</b>	<b>20</b>	<b>4,200</b>	<b>340</b>
	<b>TOTAL</b>	<b>26,583</b>	<b>905</b>	<b>44,087</b>	<b>1,489</b>	<b>47,455</b>	<b>1,702</b>	<b>46,652</b>	<b>1,579</b>	<b>44,564</b>	<b>1,610</b>	<b>41,924</b>	<b>1,424</b>	<b>37,909</b>	<b>1,291</b>	<b>289,174</b>	<b>10,000</b>
	<b>GOI CONTRIBUTION</b>		<b>848</b>		<b>902</b>		<b>955</b>		<b>1,008</b>		<b>1,061</b>		<b>1,114</b>		<b>1,114</b>		<b>7,000</b>
	<b>PROJECT TOTAL</b>	<b>26,583</b>	<b>1,753</b>	<b>44,087</b>	<b>2,390</b>	<b>47,455</b>	<b>2,657</b>	<b>46,652</b>	<b>2,586</b>	<b>44,564</b>	<b>2,671</b>	<b>41,924</b>	<b>2,537</b>	<b>37,909</b>	<b>2,405</b>	<b>289,174</b>	<b>17,000</b>

\* Dollar Costs

\*\* Dollar Costs: \$100,000 in year 3, and \$100,000 in year 5 for evaluation.

\$ represents equivalent dollar costs of Rupees converted @ Rs.30 to a dollar.

TABLE 7.2. (Contd..)

## AIDS PREVENTION AND CONTROL PROJECT (386-0525)

EX.RATE (\$1 =)

ILLUSTRATIVE SUMMARY OF PROJECT BUDGET (fig.in '000)

30 Rupees

	COST CATEGORY	YEAR 1		YEAR 2		YEAR 3		YEAR 4		YEAR 5		YEAR 6		YEAR 7		GRAND TOTAL	
		Rs.	\$	Rs.	\$	Rs.	\$	Rs.	\$	Rs.	\$	Rs.	\$	Rs.	\$	Rs.	\$
	<b>Base Cost</b>																
1.	<b>ADMINISTRATION</b>																
A.	Prof Salary & Benefits	1,000	33	1,000	33	1,000	33	1,000	33	1,000	33	1,000	33	1,000	33	7,000	233
B.	Support Staff Sal & Benefits	130	4	130	4	130	4	130	4	130	4	130	4	130	4	910	30
C.	Domestic Travel	130	4	130	4	130	4	130	4	130	4	182	6	182	6	1,014	34
D*	International Travel		18		18		18		20		20		20		20		134
E.	Communications & Utilities	250	8	250	8	250	8	250	8	250	8	250	8	250	8	1,750	58
F.	Start-Up Costs and Office Expense	900	30	900	30	900	30	990	33	990	33	990	33	1,094	36	6,764	225
G.	Equipment - Capital	1,350	45			500	17			500	17					2,350	78
H.	Vehicle - Rental	390	13	390	13	520	17	520	17	650	22	650	22	520	17	3,640	121
I.	Contractual Services	200	7	150	5	150	5	150	5	150	5	150	5	150	5	1,100	37
	<b>SUB-TOTAL.</b>	<b>4,350</b>	<b>163</b>	<b>2,950</b>	<b>116</b>	<b>3,580</b>	<b>137</b>	<b>3,170</b>	<b>126</b>	<b>3,800</b>	<b>147</b>	<b>3,352</b>	<b>132</b>	<b>3,326</b>	<b>131</b>	<b>24,528</b>	<b>952</b>
2.	<b>NGO GRANTS</b>	<b>12,000</b>	<b>400</b>	<b>19,500</b>	<b>650</b>	<b>19,500</b>	<b>650</b>	<b>129,000</b>	<b>4,300</b>								
3.	<b>NGO SUPPORT &amp; DEVELOPMT.</b>																
A.	IEC	1,600	53	2,500	83	2,500	83	2,500	83	1,600	53	1,600	53	800	27	13,100	437
B.	STD Counselling	250	9	312	10	312	10	312	10	208	7	208	7	208	7	1,820	61
C.	Promotion of Condoms	3,400	113	10,400	347	10,400	347	8,300	277	6,200	207	4,200	140	2,100	70	45,000	1,500
D.	Coordination	2,200	73	2,200	73	2,200	73	2,200	73	2,200	73	2,200	73	2,200	73	15,400	513
	<b>SUB-TOTAL</b>	<b>7,460</b>	<b>249</b>	<b>15,412</b>	<b>514</b>	<b>15,412</b>	<b>514</b>	<b>13,312</b>	<b>444</b>	<b>10,208</b>	<b>340</b>	<b>8,208</b>	<b>274</b>	<b>5,308</b>	<b>177</b>	<b>75,320</b>	<b>2,511</b>
4.	<b>RESEARCH</b>	<b>1,500</b>	<b>50</b>	<b>2,300</b>	<b>77</b>	<b>2,300</b>	<b>77</b>	<b>2,300</b>	<b>77</b>	<b>1,500</b>	<b>50</b>	<b>750</b>	<b>25</b>	<b>400</b>	<b>13</b>	<b>11,050</b>	<b>368</b>
5.**	<b>EVALUATION &amp; AUDITS</b>	<b>600</b>	<b>20</b>	<b>600</b>	<b>20</b>	<b>600</b>	<b>120</b>	<b>600</b>	<b>20</b>	<b>600</b>	<b>120</b>	<b>600</b>	<b>20</b>	<b>600</b>	<b>20</b>	<b>4,200</b>	<b>340</b>
	<b>TOTAL</b>	<b>25,910</b>	<b>882</b>	<b>40,762</b>	<b>1,377</b>	<b>41,392</b>	<b>1,498</b>	<b>38,882</b>	<b>1,316</b>	<b>35,608</b>	<b>1,307</b>	<b>32,410</b>	<b>1,100</b>	<b>29,134</b>	<b>991</b>	<b>244,098</b>	<b>8,471</b>

\* Dollar Costs

\*\* Dollar Costs : \$100,000 in year 3, and \$100,000 in year 5 for evaluation.

\$ represents equivalent dollar costs of Rupees converted @ Rs.30 to a dollar.

TABLE 7.2. (Contd..)

AIDS PREVENTION AND CONTROL PROJECT (386-0525)

ILLUSTRATIVE SUMMARY OF PROJECT BUDGET (fig. in '000)

COST CATEGORY	YEAR 1		YEAR 2		YEAR 3		YEAR 4		YEAR 5		YEAR 6		YEAR 7		GRAND TOTAL	
	Rs.	\$	Rs.	\$	Rs.	\$	Rs.	\$	Rs.	\$	Rs.	\$	Rs.	\$	Rs.	\$
<b>Inflation</b>																
<b>1. ADMINISTRATION</b>																
Prof. Salary & Benefits	60	2	187	6	330	11	489	16	668	22	868	29	1,092	36	3,694	123
Support Staff Sal & Benefits	8	0	24	1	43	1	64	2	87	3	113	4	142	5	480	16
Domestic Travel	8	0	24	1	43	1	64	2	87	3	158	5	199	7	582	19
International Travel		0		1		2		4		5		6		7		26
Communications & Utilities	15	0	47	2	82	3	122	4	167	6	217	7	273	9	924	31
Start-Up Costs and Office Expense	18	1	56	2	99	3	191	6	260	9	339	11	540	18	1,502	50
Equipment - Capital	81	3			165	5			334	11					580	19
Vehicle - Rental	23	1	73	2	171	6	254	8	434	14	564	19	568	19	2,089	70
Contractual Services	12	0	28	1	49	2	73	2	100	3	130	4	164	5	557	19
SUB-TOTAL	225	8	440	16	982	35	1,257	46	2,137	76	2,389	86	2,977	107	10,408	373
<b>2. NGO GRANTS</b>																
<b>3. NGO SUPPORT &amp; DEVELOPMENT</b>																
IEC	96	3	468	16	824	27	1,223	41	1,069	36	1,389	46	874	29	5,943	198
STD Counselling	16	1	58	2	103	3	153	5	139	5	181	6	227	8	876	29
Promotion of Condoms	204	7	1,947	65	3,429	114	4,061	135	4,141	138	3,646	122	2,294	76	19,721	657
Coordination	132	4	412	14	725	24	1,076	36	1,469	49	1,910	64	2,403	80	8,128	271
SUB-TOTAL	448	15	2,885	96	5,081	169	6,513	217	6,818	227	7,125	238	5,798	193	34,667	1,156
<b>4. RESEARCH</b>																
<b>5. EVALUATION &amp; AUDITS</b>																
<b>TOTAL</b>	<b>673</b>	<b>23</b>	<b>3,325</b>	<b>112</b>	<b>6,063</b>	<b>204</b>	<b>7,770</b>	<b>263</b>	<b>8,956</b>	<b>303</b>	<b>9,514</b>	<b>323</b>	<b>8,775</b>	<b>300</b>	<b>45,076</b>	<b>1,529</b>

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No physical contingency has been budgeted in the financial plan for any of the budget line items as: (1) estimates for activities under the line items Administration and NGO Support & Development are discrete and, therefore, have been projected with a greater degree of accuracy and certainty; and (2) in respect of other line items, such as NGO grants and Research, these represent the maximum amounts that would be made available during the Project's life.

The following provides a line by line detail for selected elements of the Estimated Budget in the currency used to estimate costs.

## 1. Administration

A. Professional Salaries and Benefits: The APAC office will have six professional staff at an average salary cost of Rs.1.5 million per year.

B. Support Staff Salaries and Benefits: The average yearly cost will be Rs. 200,000.

C. Domestic travel includes air and train travel between Madras and New Delhi and within Tamil Nadu.

D. International travel is based on two trips per year to the US and five trips within the Asia region, plus per diem.

E. Equipment-Capital includes: seven computers and printers, photocopier, fax machine, typewriter, slide projector, overhead projector, VCR plus monitor and camera, and office furniture. Partial replacement is anticipated in Years 3 and 5.

F. Office space two options are available 1) rental of 5,000 sq. ft. of space at Rs. 10 per sq.ft. per month or 2) USAID would support renovation/construction of office space by VHS for the APAC Project at a cost of Rs.400 at 5,000 sq.ft. or \$71,000.

G. Vehicle rental is proposed based on the assumption that it will be cheaper and more efficient to rent vehicles (with drivers), as needed, rather than to purchase and maintain a Project vehicle and engage a full time driver. The estimate is based on rental charges of Rs.500/day for 260 days/year times three vehicles.

H. Contractual services will cover a CPA firm or other management services required by the APAC office.

## 2. NGO Grants

It is assumed that grants will not be awarded immediately and therefore that the budget for the first year will be somewhat lower than in succeeding years. The following table indicates an estimated distribution of the average annual dollar value of NGO grants:

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### ESTIMATED ANNUAL GRANT VALUES

<u>Number of Grants</u>	<u>Average \$ Value</u>	<u>Total Cost</u>
5-6	\$75,000	\$375,000 - \$450,000
7-10	\$20,000	\$140,000 - \$200,000
31-36	\$ 5,000	\$155,000 - \$180,000
<u>Total</u> 43-52		\$670,000 - \$830,000
<u>Average</u> 47		Total cost per year : \$615,000

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Following is a description of illustrative characteristics of large, medium and small grants.

\$75,000 per year

- catchment population of more than 75,000
- conglomerate of activities, e.g., development of training modules, training workshops, outreach community-based education, condom distribution, STD treatment facilities, newsletter
- umbrella NGO with a number of sub-grantees

\$20,000 per year

- catchment population between 50,000 - 100,000
- education, condom distribution, STD services

\$5,000 per year

- catchment population of less than 25,000
- education, condom distribution, STD services

### 3. NGO Development and Support

A. The estimated annual IEC budget includes:

Formative Research	\$28,000
Design	\$26,000
Production	\$40,000

It is assumed that IEC activities will begin in about the fourth month of the Project.

B. STD counseling includes the development of counseling modules, estimated at \$4,000 each, and training workshops throughout the life of the Project, estimated at an average of \$4,000 each.

C. Promotion of Condoms

Following is an illustrative budget for an annual mass media campaign:

TV & Cinema Production	\$60,000
TV Broadcast	\$68,000
Cinema Broadcast	\$40,000
Radio Production	\$20,000
Radio Broadcast	\$64,000
Distribution/placement costs:	
Billboards	\$18,000
Press	\$36,000
Murals	\$28,600
Production costs of printed advertising materials	\$55,000
<b>TOTAL</b>	<u>\$389,600</u>

It is assumed that the condom promotion campaign will begin in the eighth month of the Year 1. APAC will finance the campaign fully through Year 3 of the Project; beginning in Year 4, the condom manufacturers will begin to take over the costs.

D. Coordination activities include workshops, at an estimated cost of \$4,000 each, and establishing the resource center.

#### 4. Research

The estimated number and dollar amount of Research grants per year is:

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#### ESTIMATED ANNUAL VALUE OF RESEARCH FUNDING

<u># of Research Projects</u>	<u>Average \$ value</u>	<u>Total cost</u>
2-4	\$20,000	\$40,000 - \$80,000
2-4	\$10,000	\$20,000 - \$40,000
<u>Total</u>	4-8	\$60,000 - \$120,000
<u>Average</u>	6	Total Cost per Year: \$53,000

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5. **Evaluation and Audits** The budget assumes external evaluations in Years 3 and 5 at \$100,000 each and an annual cost of \$20,000 for external APAC Project audits.

#### 7.2. GOI Contribution

The GOI will contribute approximately \$7 million in the form of condoms through the MOHFW-supported social marketing delivery system in Tamil Nadu, and through its free distribution of condoms for government programs. These condoms are expected to meet international standards for AIDS condoms as outlined in the GOI plan under the GOI AIDS loan with the World Bank.

The GOI contribution is calculated on the basis of total condom sales in Tamil Nadu during the life of the Project through the social marketing channels which is estimated at 191 million pieces, and the free distribution through government programs which is estimated at 147 million pieces, including the present sales and distribution through these two broad networks. The sales of social marketing condoms are expected to increase by 15% each year and is reflected in the estimate. Estimates of distribution of free condoms is straight-lined for the project period.

The value of condoms sold through social marketing channels is calculated on the basis of weighted average of the subsidy given to these distributing organizations by GOI which works out to 55 paise (1.83 US cents) per piece, with the product price subsidy accounting for 51 paise (1.7 US cents) and marketing subsidy of 4 paise (0.13 US cents) per piece. The free distribution of condoms is valued at GOI weighted average procurement price of 71 paise per piece. These estimates are considered to be conservative given the fact that the GOI procures most of its condoms from a government-owned parastatal which is itself subsidized, and that upgrading required to meet international standards has not yet been costed.

Given the Project's condom sales objectives, the GOI contribution is both appropriate and necessary. While the requirement for socially marketed condoms will depend in part on the, as yet undetermined, ability of the private sector to increase sales, it is estimated that the social marketing program in Tamil Nadu is likely to sell approximately 191 million condoms, and the GOI will be able to meet its commitment to maintain its present free distribution level aggregating to 147 million condoms, over the next seven years. A \$7 million in-kind contribution by the GOI would translate into just that many condoms.

The GOI contribution in the form of free distribution and through ITC in Tamil Nadu will be monitored through periodic monitoring reports.

### 7.3. Disbursement Procedures

**Local Currency Costs:** The entire Project cost, with the exception of International Travel (\$160,000) and Evaluation (\$200,000), will be in local currency. It is assumed that all sub-grants and contracts in local currency will be entered into by VHS, with whom A.I.D. proposes to sign a cooperative agreement. A.I.D. will make payments to VHS for costs in the form of periodic advances, based on an assessment of immediate disbursement needs, not exceeding 90 days' requirements, which will be liquidated every month on the basis of expenditure statements and SF 1034 vouchers submitted by VHS to A.I.D. directly. The expenditure statement will also show monthly projection of expenditures to facilitate payment of further advances for the specified period.

**Foreign Exchange Costs:** As specified above, the grantee will submit appropriate expenditure statements for dollar costs separately either for reimbursement or direct payment by A.I.D. Such reimbursements are, however, contingent upon the grantee obtaining the required permissions from the Government of India for receiving foreign exchange.

A.I.D. will enter into direct contracts for evaluation, non-federal audits, and payment verifications and pay for these expenses directly to the contractors.

#### 7.4. Methods of Implementation and Financing

The methods of implementation and financing of the various Project elements are shown in Table 7.3.

TABLE 7.3  
METHOD OF IMPLEMENTATION AND FINANCING<sup>9</sup>

ITEM	METHOD OF IMPLEMENTATION	METHOD OF FINANCING	ESTIMATED COST (\$ 000)
-Administration -NGO Grants -NGO Support & Development -Research	Cooperative Agreement with VHS and local contracts/ subgrants between VHS and indigenous institutions	Host Country Reimbursement/ Advances	9,660
Payment Verifications Evaluation Non-Federal Audits	Direct Contracts	Direct Payment	340
		TOTAL	10,000

The Project will be implemented by VHS, an NGO. In order to reduce the Mission vulnerability and meet the criteria of cash management policies, an analysis of the implementing agency's administrative and financial capabilities, financial practices and procedures was carried out by USAID Mission staff in May 1992. The findings of the assessment team are Annexes J3 and J4 of this Paper.

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<sup>9</sup>The above cost is inclusive of price contingencies. It is only illustrative and may undergo changes between Direct Payment and HC Reimbursement/Advances based upon the exigencies of the situation at the time of actual implementation.

During Project implementation, the Mission will carry out payment verification reviews through reputable Certified Public Accountant (CPA) firms for which funds have been budgeted in the Project. The Mission will also carry out financial monitoring of the Project-funded activities through its own analysts on a selective basis. These reviews and the Project Officer's monitoring will be sufficient to fulfill A.I.D. financial monitoring responsibilities as well as in identifying and correcting any problems.

VHS is a voluntary services organization registered under the Societies Registration Act. Under the Articles of Association of the organization, it is incumbent upon VHS to get its accounts audited by a Chartered Accountant (Indian equivalent of CPA) every year. The cooperative agreement with VHS will include the Mandatory Standard Provision on "Accounting, Audit, and Records" which requires annual audits of AID funds as per the Inspector General's (IG's) new policy on recipient-contracted audits. These audits will be performed by local CPA firms who are on the Regional Inspector General's (RIG's) approved list. The IG's "Guidelines for Financial Audits Contracted by Foreign Recipients" and the Statement of Work for such audits provided by the RIG will be followed in conducting the audits. In the case of sub-grantees who receive \$25,000 or more per year under this Project, the grantee (VHS) shall require them to have audits performed in accordance with the Mandatory Standard Provision. A provision of \$55,000 over the life of Project has been made for such recipient-contracted audits and for professional accounting services to be obtained by VHS for regular internal control reviews. In addition, A.I.D. will have access to the grantee's and subgrantees' records and will directly contract for non-federal audits if determined necessary. An amount of \$20,000 has been provided per year for such non-federal audits.

#### 7.5. Recurrent Cost Analysis and Sustainability

The Project provides \$1.3 million over its seven-year life for "Administration" which is in the nature of operating cost support for the VHS's incremental costs associated with project activities. It is assumed that project activities after project completion will be sustained by the GOI, other donor agencies, and the NGO community. The proposed World Bank loan of \$84 million is expected to institutionalize the provision of government funds to NGOs for AIDS work on a nation-wide basis. During the Project, VHS and its NGO grantee are expected to acquire the necessary administrative and financial expertise in their programs in support of AIDS prevention and control. A number of activities such as condom promotion and distribution will be largely taken over by the private sector. Although the incremental variable (program-related) costs are funded by USAID, there are certain overheads associated with the Project activities which are proposed to be absorbed by VHS under the Project activities. As such, the demand on VHS to sustain its activities is likely to be minimal restricted only to the variable costs with non financial support from A.I.D.

## 8. SUMMARY OF PROJECT ANALYSES

### 8.1. Technical Analysis

Since the first description of AIDS appeared in the medical literature in 1981, the general philosophy toward control has been to employ a wide spectrum of approaches to prevent transmission of HIV and reduce mortality and morbidity associated with HIV infection.

An inherent weakness, early in the fight against AIDS, was a lack of systems for monitoring and evaluating the efficacy of these varied interventions. Until very recently, the international health community was unable to determine what worked and what didn't. In 1991, a major review of the Agency for International Development's worldwide AIDS control activities since 1986 was performed.

During that review, seven major lessons became apparent.

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### 7 LESSONS LEARNED

- (1) We can prevent HIV infection on a limited basis.
  - (2) Increasing demand for and access to condoms has been a key part of success to date.
  - (3) Treatment and diagnosis of STDs play a major role in prevention and control of HIV infection.
  - (4) We have had the greatest success with NGOs and PVOs which have been able to mobilize rapidly and respond to the current crisis.
  - (5) We have not had an impact on HIV infection at the national level, in part, because of lack of concentration of resources.
  - (6) We need to learn more about communications for behavioral change and about sexual behavior in order to refine prevention and control strategies.
  - (7) We have learned about the critical importance of multiple reinforcing channels of communication aimed at changing knowledge and attitudes of individuals and societies toward sexual behavior, as a prelude to behavior change.
-

Applying the first three lessons, the APAC Project will focus on the following three key interventions which have been shown to be the most important and effective in preventing and controlling AIDS:

Promote behavior change to reduce sexual partners and high risk sexual behavior:

Research shows that 75% to 80% of all HIV transmission is through sexual intercourse. This significantly increases with an increased number of sexual partners, due simply to the greater probability of having sexual intercourse with an infected person. Populations that regularly engage in high risk sexual activity (multiple partners, frequent use of commercial sex workers, etc.) have been shown to be amplifiers early in the AIDS epidemic and are thus termed "core transmitters." "Core transmitters" is an epidemiologic concept designating a relatively small group of individuals who are directly or indirectly the source of a disproportionately high number of infections. According to recent modeling exercises, **when a case of HIV infection is prevented in the core group, the total health impact is three to six times greater than preventing a case in the non-core group.**

Increase demand and access to condoms: Condoms are the only physical barrier available that can stop the sexual transmission of the virus from one person to another. **The probability of sexual transmission by an HIV infected female to an HIV-negative male is approximately 1 in 1000; the probability from an infected male to an uninfected female is 1 in 500.** Increasing evidence from the U.S., Europe, and Africa shows that condom use protects against HIV infection. Condoms are found to be approximately 85-90% effective when considering the combination of user and method failure. However, the more consistently condoms are used, the more protection they provide. Programs that promote and distribute condoms to those who practice high risk sexual behavior have been very successful.

Improve STD services: Patients with STDs are, by definition, engaging in high risk behavior. They constitute a logical target for specific HIV/AIDS IEC campaigns: As patients, they are accessible; moreover, they are often relatively open to behavior modification, due to the presence of uncomfortable symptoms. The presence of an STD multiplies the efficiency of transmission of HIV from 5 to 20 times. **The probabilities of transmission for both sexes rise to 1 in 200 when an STD is present, and to 1 in 20 when the STD leads to genital ulcer sores, such as syphilis, chancroid and herpes, provide physical portals of entry and exit for the AIDS virus.** Effective treatment regimens for all of the common STDs, except herpes, are now available, using either syndrome management protocols or laboratory based diagnoses. The combined positive impact of targeting STD patients with special HIV/AIDS prevention messages and decreasing the prevalence of STDs and thus their multiplying effect on HIV transmission, make the improvement of STD services a powerful weapon in controlling the AIDS epidemic.

Along with the relatively more promising interventions, APAC will adopt an approach that reflects the programmatic "*lessons learned*" during the last seven years of A.I.D. involvement in AIDS prevention. Applying Lesson 4 - Success with NGOs -- activities will be implemented mainly by non-governmental organizations. Applying Lesson 5 -- Concentrate resources -- there will be a focus of resources on high risk groups in the State of Tamil Nadu. This will avoid spreading resources too thinly and help ensure a positive and documented impact on HIV prevalence. Applying Lesson 6 -- Need for research -- there will be a major emphasis on research to study knowledge, attitudes and behaviors of target populations. Information from this research will be synthesized continually and fed back into the Project to improve effectiveness of communications efforts. Applying Lesson 7 -- Importance of multiple reinforcing communication channels -- there will be a variety of communications approaches including mass media, folk media, interpersonal communication and counseling to bring about behavior change.

## 8.2. Economic Analysis

Demographically speaking, AIDS will affect mortality, possibly fertility, the rate of population growth and the age structure although it is not possible to project these effects with any precision. Mortality can be estimated if HIV prevalence is known; however, the future level of HIV is difficult to predict. Therefore, mortality rates cannot be estimated with accuracy over the long term. Fertility rates are also difficult to estimate since it is impossible to determine how people will react to AIDS in their family size decisions.

Decreased productivity during sickness and the premature death of productive individuals will have an effect on the economy as a whole. With AIDS, the loss can be expected to affect people of all income levels unlike other preventable or curable diseases which mainly affect the poor. Additionally, when adults die, family and community incomes are strained by the financial requirements of dependents, comprised of surviving partners, orphans and the elderly.

Since AIDS affects adults in their prime productive years, labor shortages may be experienced in regions of the country and in some of the highly skilled job categories in urban areas. Losses will also be felt due to decreased productivity. If the epidemic spreads into rural areas, food security may also be affected.

In countries in which there is already a significant AIDS epidemic, the cost of AIDS prevention and control activities, and particularly the care of AIDS patients, represents a significant proportion of government health expenditures. Staff and facilities are being swamped with AIDS related tasks.

In Tamil Nadu, the average cost per day for inpatient care of an AIDS patient is estimated at Rs. 500. Most AIDS patients will have multiple hospital admissions until death, requiring an average of approximately six weeks of hospital care. This would generate an average cost per patient of Rs. 22,000 or approximately \$750.<sup>10</sup> If the APAC budget were used solely for patient care, approximately 13,500 people would benefit. The proposed preventive strategy is expected to reach approximately three million people at an average cost of \$3.33 per capita.

It is also important to consider whether the selected interventions to be undertaken through APAC represent the least-cost methodologies, given the currently available and socially acceptable technical approaches. The Project will incorporate the most advanced methods and strategies that have already been shown to be effective, in India and worldwide. Results of ongoing programs and studies (both in India and elsewhere) will be monitored by Project staff throughout the period of Project implementation. As new project activities are planned, the Project will incorporate materials and methodologies that have proven most effective. This flexibility, built into the Project design, will assure that the cost effectiveness of Project interventions are maximized.

### 8.3. Social Soundness and Women in Development (WID) Analysis

The design team determined that the interventions proposed are implementable, though socially and culturally sensitive. Women will receive direct benefits from this Project by improvements in access to information and services on reproductive health. The social soundness analysis provided information on cultural attitudes and practices, and aspects of societal organization relevant to the Project. Major points are summarized below.

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<sup>10</sup>These estimates are based on the costs and attendance observed at the Christian Medical College in Vellore which treats both HIV opportunistic diseases and cares for full-blown AIDS cases. None of the expensive life extending measures used in other countries (e.g., AZT) are being used in Tamil Nadu and are thus not included in the estimate.

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**APAC's prevention strategy will save lives and money.**

The Project will provide \$10 million for AIDS prevention. If this amount were to be used solely for patient care, approximately 13,500 persons would benefit.

Alternatively, the allocation of these resources is expected, through the strategies of targeted education, condom promotion and improving the quality of STD services, to benefit approximately 3,000,000 persons in the State of Tamil Nadu, at a cost of \$3.33 per person.

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### 8.3.1. Groups at High Risk for HIV

The emerging profile of high risk behavior groups indicates that these include people with multiple sex partners, STD patients and their sexual partners, male homosexuals and bisexuals, and sexually exploited groups like street children, domestic servants, and women in the entertainment industry.

Prostitution takes varied forms in India, including brothel prostitutes, call girls, and women working on the streets. Many women engage in prostitution intermittently, coming in to towns from the rural areas. In general, prostitutes have no access to information related to health and birth control, and seek STD treatment only when it may affect their business. Preliminary research in Madras has suggested a typology of prostitutes that divides them into eight categories (1) "pavement" prostitutes (who have sex in the streets), (2) streetwalkers (who take clients to small hotels), (3) brothel workers, (4) workers in "moving brothels" (using a rented house that may be changed frequently to avoid arrest), (5) part-time sexworkers, (6) bar girls working in large hotels, (7) call girls (working through a pimp), and (8) prostitutes working at truck stops. Available information suggests that access to health services, knowledge about STDs/AIDS and extent of condom use differs widely. Therefore, profiles of particular groups of sexworkers and their clients will have to be defined as project activities are developed for these groups.

Men with multiple partners, including clients of prostitutes, constitute a highly heterogenous group. Especially vulnerable subgroups have been identified, such as; regular travellers, (e.g., salesmen); migrant populations, and members of particular industries as well as street youth, alcoholics and drug addicts, and male prostitutes. It is difficult to gauge the size of this group, but it should be noted that those in deprived socio-economic groups are likely to be at greater risk because of lack of information, poor access to services, and poor health.

Groups that may be hard to reach because of their need for confidentiality or their marginal existence include STD patients, male homosexuals, street children, and domestic servants. The two latter groups are particularly vulnerable to sexual exploitation.

### 8.3.2. Attitudes Toward Sexuality

Traditional attitudes in India towards sexuality are generally unaccepting of extra- or pre-marital relations by women, but take a more tolerant view of males with multiple partners. Male sexuality may be public and proved to the world through overt virility; visits to prostitutes in the company of other men fall into this category. There is a tacit acceptance of alternate forms of sexuality (such as the eunuch community) but homosexuality as a regular, exclusive way of life is surrounded by secrecy and mistrust.

Prostitutes, who are viewed by the law as victims of society, are publicly held in low esteem. This negative image has serious implications in terms of targeting prostitutes as reservoirs of infection, almost to the exclusion of clients and others whose behavior may place them at high risk. One study notes that, like other STDs, AIDS is viewed as a female disease because of the belief that women with many partners are major transmitters. The few in-depth studies of sexual behavior show a constellation of high risk activities related to sex with prostitutes: low condom use, the combination of commercial sex and alcohol, and some occurrence of anal sex.

Traditionally, the woman is expected to be a passive partner in the sexual relationship; the culture also stresses self-sacrifice on the part of the woman. Recent studies, however, show a gradual liberalization of these attitudes to sexuality among more urbanized women. Nevertheless, women are generally not in a position to take an active part in condom use or in changing the behavior of men with multiple partners.

### 8.3.3. Attitudes Towards Condom Use

Since the initiation of the family planning program in India, there has been a growing acceptance of the condom as an effective contraceptive and awareness of this method is high. "Nirodh" the condom issued by the government health services, is well known and, in fact, has become the generic word for condom. Condoms are available free of charge at public health facilities, at subsidized prices from social marketing outlets, and commercially from retail outlets.

Recent studies indicate that condoms are preferred by younger users (up to age 30), infrequently used in commercial sex, and not commonly identified as a barrier method against STDs. Unfortunately, condom quality and especially negative perceptions about Nirodh, is a liability. Social attitudes to condoms have also been a major stumbling block to usage: despite general availability, there is still embarrassment about buying or displaying condoms openly. The government's free distribution network has contributed to the image of a cheap, low-quality product. Storage and disposal are equally important problems that are reported to deter use.

Social promotion of condoms has been an important factor in their acceptance. Social marketing, supported by government, is now expanding to include integrated campaigns for rural as well as urban areas. Some of the promotion is carried out by voluntary organizations and the private sector that have introduced more explicit and life-style oriented condom marketing campaigns (such as those for the new brands Kamasutra and Masti). Most condom campaigns, however, are provocative rather than educative and almost no publicity is given to correct condom use.

#### 8.3.4. Health Seeking Behavior Related to HIV/STD

In urban areas Municipal Corporations provide specialized services through hospitals, dispensaries, and STD clinics, supplemented by the Urban Health Posts Scheme operating in slum areas. Currently the health services are primarily curative and institution based, do not have adequate treatment facilities or personnel, and are not equipped to provide education to counteract mistaken beliefs and change behavior.

An extensive network of private health care also exists, including private practitioners and NGOs. This system is responsible for 2/3 of medical manpower and 2/3 of the expenditure on health. Alternative systems of medicine are also important. According to a recent study approximately 75% of the demand for consultation is met by practitioners of traditional medicine, some of whom treat sexual problems. Folk practitioners and quacks are frequently the first persons consulted in matters related to sex.

Utilization of health services is affected both by the perception of the service itself, by the individual's response to illness, and by perceptions of the provider. Direct and indirect costs, perceptions of the service providers, and cultural factors all contribute to utilization. Preventive services are likely to be seen as less important and early treatment may be ignored because of the lack of visible symptoms, the perceived lack of seriousness of the disease, or the availability and costs of taking action. Treatment itself is restricted to drug therapy and doctors do not generally discuss the use of condoms. Owing to their lower status, women's health is not seen as important as men's and women may be particularly reluctant to seek preventive care. In addition, where there is no female health provider women are embarrassed to come in for gynecological check-ups. Research also indicates that acceptance of health services is affected by the patients' confidence in meeting with compassion and reassurance from the doctor.

The prevalence of STDs is not clearly known in India, but it is estimated that one out of every 25 adults suffers from some form of STD. VDRL surveys among vulnerable groups indicate that STDs are on the rise despite the availability of antibiotics. Recent studies indicate that STD patients are predominantly young (between 16-30 years); contacts with multiple partners, usually prostitutes, are common; that most patients delay treatment, initially consulting quacks and chemists, and only visiting medical clinics as a last resort; and the knowledge about STDs among patients is inadequate.

There is awareness about AIDS but little knowledge about the causes: misconceptions include notions of casual contact; persons, such as prostitutes, rather than behavior is seen as the cause of infection; and low risk-assessment is common, due either to the close linkage made between AIDS and STDs, which are seen as curable, or because of the low number of reported cases in India.

Sex education programs, at the interpersonal and mass level, are virtually nonexistent. There are inhibitions related to discussing sex although reproduction and childbirth are discussed more openly, especially with women. There are few socially approved opportunities for school and college youth, adolescent girls, out-of-school youth, or working men to learn about sex. Popular press is therefore the major source of education for literate youth, followed by friends, and soft porn audio visuals and books. When sex education is provided in schools, it is usually oriented towards physiology or morality rather than toward emotional and real life issues and dilemmas. There is also a paucity of trained sex education experts. STDs are not seen as an appropriate topic for sex education for young people, especially girls, because of the implied comment on their sex lives.

Several barriers exist to establishing effective treatment programs, including perceptions that only a small percentage of the population is involved, taboos against sex education, lack of training of health workers in counseling and education, limited treatment facilities and the stigmatization of those who use them, poor follow-up of patients, and a neglect of preventive services.

#### 8.3.5. The Family as a Support System

The family remains the primary means of social support and has a strong potential both for care of HIV-infected persons and in facilitating the altering of behavior for prevention. The strength of the Indian family can be exploited in communication campaigns that create a social ethos encouraging families to encourage behavior change and provide needed support. For example, messages targeted to different occupational groups or age groups are likely to be pooled at the family level through intra- and inter- household communication.

#### 8.4. Administrative Analysis

During the PP design, a review of organizations in Tamil Nadu was completed to identify one or more organizations capable of implementing the APAC Project and to determine whether the state had entities capable of undertaking APAC prevention interventions, support activities or research. The review determined that:

- Voluntary Health Services would be an appropriate institution to implement Project activities.
- RD/H AIDSCAP Project could provide valuable assistance to the APAC Project.

- Tamil Nadu has a large number of NGOs capable of undertaking the prevention interventions proposed under this Project; however, they will need technical support.
- A wide range of field, consulting and research experience in the health and social sectors exist in Tamil Nadu.
- Tamil Nadu has an extensive condom distribution and social marketing program.
- Tamil Nadu has a fairly extensive health infrastructure delivery STD services up to the District level.

#### 8.4.1. Voluntary Health Services, Madras

VHS is a well respected NGO in Tamil Nadu with over 25 years of experience and a good track record with USAID and other GOI and donor supported activities. With an annual budget of approximately \$1 million, VHS is among India's largest NGOs dedicated to primary health care. Its Governing Council includes a number of national luminaries, including the State Attorney General and Accountant General. Situated in Madras, VHS has been operating runs a 300 bed hospital, has 340 full-time equivalents, 40 part-time staff and numerous volunteers. It is sustained through donor funds, private donations and some fee-for-service activities.

VHS was a sub grantee of the USAID/India PVOH-I Project and received consistent outstanding evaluations. It has several grants from GOI and donor institutions which are implemented within VHS as separate projects. APAC will be one such project.

#### 8.4.2. RD/H AIDSCAP Project

The RD/H AIDS Control and Prevention (AIDSCAP) Project is a \$65 million cooperative agreement awarded to Family Health International in FY 1991. AIDSCAP focuses on directing funds primarily to priority countries to assure that the assistance will have an impact on the spread of the disease. Its primary interventions are condom promotion, the early treatment of STDs, and partner reduction. AIDSCAP is committed to the use of community-based programs aimed at reducing high-risk behavior and to maintaining policy dialogue on AIDS-related issues at the national level. AIDSCAP is based in Washington D.C. and has field offices in various regions, including one in Bangkok which covers India.

### 8.4.3. Non-Governmental Organizations

The APAC Project will be implemented primarily through non-governmental organizations (NGOs). NGOs have the advantage of being able to carry out innovative programs because of their voluntarism. They work at the grassroots level and therefore are able to carry out community based programs more efficiently without the constraints of bureaucratic rules and regulations. By working through these organizations, the APAC Project will be able to reach a large number of people. NGOs have better access to the target groups identified by APAC.

In Tamil Nadu there are a large number of NGOs both in the cities and the rural areas. In Madras city alone, there are over 263 NGOs of which more than 100 are working with target audiences the APAC Project must reach. Many of these NGOs are not presently involved in AIDS prevention; however, with some technical assistance from APAC they could add AIDS control education and services to their current programs.

Many NGOs in Tamil Nadu have already been identified as appropriate and interested in implementing APAC activities, including the social marketing of condoms. The NGOs fall into four groups: 1) NGOs that could provide education at community level and in the workplace, 2) those that could provide STD counseling and services, 3) NGOs that have the capability to carry out research activities, and 4) those that could be involved in the preparation of interpersonal IEC materials.

Interpersonal education: There are a large number of NGOs in Tamil Nadu that have health volunteers, or Community Health Workers (CHWs), who are grassroots workers belonging to the communities they serve and are often selected by the community. They act as "change agents," educating people to change practices and referring them to clinics for maternal and child health services. Other NGOs involved in non-formal education programs for adults and out of school youth have animators, selected from the community, who are responsible for educating illiterate adults and youth. NGOs have expressed an interest in involving CHWs and animators in educating the community in safe sexual practices, including partner reduction and condom use, in referring people for STD services and in selling condoms.

NGOs providing primary health care in both urban and rural communities are interested in involving members of the health team, including multipurpose health workers and doctors, in AIDS prevention. Since they are responsible for giving intramuscular injections of antibiotics and vaccines, they also need to be trained in sterilization techniques.

Many NGOs work with organized community groups such as women's clubs and youth clubs. These groups play an important part in development and welfare programs. They are influential in the community and can be used for education. These clubs often use traditional

media, such as *villupattu* (string instrument) and *kathakalashepam* (recitation of epics with vernacular explanations), for creating social awareness in the community.

A few NGOs have organized programs to provide sex education in schools and colleges. Initially there was apprehension among the principals and teachers. However, the programs have been so successful that requests have been received to expand these educational programs to other institutions.

There are also a number of NGOs that work with street children, school dropouts, destitute homes and vocational training centers that could provide education to these highly vulnerable groups. Several NGOs in Tamil Nadu have begun AIDS education with prostitutes, truck drivers and other high risk groups in the community.

A few preliminary activities have been organized to provide AIDS prevention education in the workplace. Individual industrialists, union leaders and management associations have expressed an interest in expanding these efforts. The Government's Board for Workers Education, chambers of commerce, railway and port authorities, and individual companies could be involved.

The National Service Scheme (NSS) is being implemented in most educational institutions. NSS students can take on the responsibility of providing educational activities, especially in slums in the neighborhoods of their institutions. WHO organized a training program for NSS coordinators in Tamil Nadu through two schools of social work. This program could be expanded.

STD Services and Counseling: A large proportion of STD patients are treated by general practitioners and these GPs will need continuing education to improve the quality of the services they provide. The Women Doctors Association has begun a training program in STD case management and counseling which can be expanded. The Indian Medical Association, with branches in all of the cities and towns in Tamil Nadu, can play an active role in this training as well.

Another way to expand STD services and improve the quality of STD management is to integrate STD services with preventive and promotional activities such as immunization, antenatal care, health education and family planning. Several NGOs that have MCH and family planning clinics have indicated a willingness to add STD services. Some of these NGOs have doctors who will need training, along with the private practitioners. One NGO that does not have qualified doctors, is collaborating with a local medical school which provides post graduates and professors. Such arrangements could be made with the Women Doctors Association and other medical colleges. One approach that has already been used successfully to expand the reach of an integrated clinic program is a system of franchising with general practitioners who can refer patients to the clinic when necessary.

NGOs that may be involved in providing STD counseling services to government clinics or in collaboration with other NGOs include women's voluntary services and religious counseling centers. Some NGOs have cells providing legal aid and other counseling services that can be expanded to provide STD counseling.

Research: A number of institutions have been identified that can carry out rapid assessments and applied research activities including schools of social work, health and welfare institutions and private consulting firms. These institutions will need technical assistance to carry out larger behavioral research studies. This technical assistance could be provided by a consultant from Tamil Nadu, elsewhere in India or, if necessary, from overseas. The modus operandi can be adopted from a private firm in Tamil Nadu that uses individual consultants to design and monitor research that can be implemented with the help of a school of social work or another institution.

There are several NGOs in Tamil Nadu that have extensive experience in epidemiologic research and evaluation and in statistical analysis.

IEC materials development: Several institutions in Tamil Nadu have established IEC units, including public sector organizations and NGOs. The materials prepared by these organizations are widely used throughout Tamil Nadu. These centers have the capability of pretesting messages and visual presentations. They have produced a range of materials, including flash cards, posters, flannelgraphs and videos.

The use of folk media has also become very popular and several institutions have experience in producing puppet shows and street plays with social messages.

Advertising and market research: There are a number of highly qualified private sector agencies that have extensive experience in market research and advertising for the social sectors. The GOI and the GOTN are using expertise from the private sector for research and promotional activities in conjunction with the AIDS control program.

# **AIDS PREVENTION AND CONTROL (APAC) PROJECT (386-0525)**

## **ANNEXES TO PROJECT PAPER**

- A PID Approval
- B Logical Framework Matrix
- C Letter of Request for Assistance from DEA
- D Letter of Interest in Participation from VHS
- E Statutory Checklist
- F Environmental Statement
- G Technical Analysis
- H Economic Analysis
- I Social Soundness and WID Analysis
- J Administrative Analysis
  - J1 Assessment of NGOs in Tamil Nadu
  - J2 Schools of Social Work
  - J3 Administrative Assessment of Voluntary Organizations
  - J4 Financial Capability Assessment of Voluntary Organizations
  - J5 Sample Format - Grant Agreement to an NGO
  - J6 Adequacy of Accounting and Reporting System  
(to be used to determine the capability of a Grantee  
to account for USAID funds)
- K Annual Report for Voluntary Health Services
- L Estimated AIDSCAP Budget
- M Conditions Precedent and Covenants

FACESHEET (PID)

ANNEX A

COUNTRY/ENTITY <b>INDIA</b>		B. PROJECT NUMBER <b>386-0525</b>	
BUREAU/OFFICE <b>ASIA</b>		B. PROJECT TITLE (maximum 40 characters) <b>AIDS Prevention and Control (APAC)</b>	
ESTIMATED FY OF AUTHORIZATION/OBLIGATION/COMPLETION		7. ESTIMATED COSTS (\$000 OR EQUIVALENT, \$1 = )	
A. Initial FY <b>92</b>		FUNDING SOURCE	
B. Final FY <b>97</b>		LIFE OF PROJECT	
C. PACD <b>99</b>		A. AID <b>10,000</b>	
		B. Other U.S. 1. 2.	
		C. Host Country/NGOs <b>3,300</b>	
		D. Other Donor(s)	
		TOTAL <b>13,300</b>	

B. PROPOSED BUDGET AID FUNDS (\$000)

A. APPROPRIATION	B. PRIMARY PURPOSE CODE	C. PRIMARY TECIL CODE		D. 1ST FY 92		E. LIFE OF PROJECT	
		1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan
AIDS				2,000		10,000	
TOTALS				2,000		10,000	

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

10. SECONDARY PURPOSE CODE

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

A. Code							
B. Amount							

2. PROJECT PURPOSE (maximum 480 characters)

The purpose of this project is to reduce the transmission of Human Immunodeficiency Virus (HIV) in the project area by focusing on interventions demonstrated to have the greatest impact on the spread of HIV such as condom use, treatment of Sexually Transmitted Diseases (STDs), and partner reduction.

5. RESOURCES REQUIRED FOR PROJECT DEVELOPMENT

Staff: USAID PDPS - 1 person month  
 IPIH - 3 person months  
 AID/W - RD/H/AIDS staff - 1 person month  
 Contractors (3) - 3 person months

Funds \$45,000 of PD&S funds obligated in FY 91 for a buy-in to the AID/W AIDS Technical Support Project for design activities.

14. ORIGINATING OFFICE CLEARANCE	Signature	Date Signed		15. DATE DOCUMENT RECEIVED IN AID/W, OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION		
	Title Office Director Office of Health, Population and Nutrition	MM	DD	YY	MM	DD

16. PROJECT DOCUMENT ACTION TAKEN

A = Approved  
 S = Suspended  
 D = Disapproved  
 CA = Conditionally Approved  
 DD = Decision Deferred

17. COMMENTS

18. ACTION APPROVED BY

Signature: [Signature]  
 Title: Director, USAID/India

19. ACTION REFERENCE  
 Delegation of Authority  
 State. 123765

20. ACTION DATE

MM DD YY  
 04 16 91

## ANNEX II – LOGICAL FRAMEWORK MATRIX

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p><b>Program Goal:</b></p> <ul style="list-style-type: none"> <li>• To reduce sexual transmission of HIV in Tamil Nadu</li> </ul>	<p><b>Measures of Goal Achievement:</b></p> <p>The stabilization or decrease of HIV seroprevalence</p>	<p>Sentinel Surveillance Data</p>	<p>Changes in behavior will occur</p>
<p><b>Project Purpose:</b></p> <ul style="list-style-type: none"> <li>• To introduce and reinforce HIV preventive behavior in at risk populations</li> </ul>	<p><b>End of Project Status:</b></p> <ul style="list-style-type: none"> <li>- Increased condom sales</li> <li>- Improved quality of STD services</li> <li>- Increased knowledge of protective measures against HIV/STD transmission</li> <li>- Increased number of NGOs involved in AIDS/STD prevention activities</li> </ul>	<ul style="list-style-type: none"> <li>- Retail distribution data</li> <li>- Clinic Observation studies</li> <li>- KAP studies</li> <li>- Project reports</li> </ul>	<p>NGO activities will result in behavior change</p>
<p><b>Project Outputs:</b></p> <ul style="list-style-type: none"> <li>• Total condom sales increased 15% per year</li> <li>• Sustained condom distribution in retail outlets and NGOs involved in AIDS prevention</li> <li>• Network of NGOs involved in AIDS prevention</li> <li>• Increased awareness of HIV/STD preventive measures and condom use</li> <li>• STD counseling/clinical management module developed</li> <li>• Behavioral and operations research studies conducted</li> </ul>	<p><b>Magnitude of Outputs:</b></p> <ul style="list-style-type: none"> <li>- 70 million condoms</li> <li>- 55,000 retail outlets</li> <li>- 100 NGOs</li> <li>- 3 million people reached through NGO activities</li> <li>- 500 individuals trained</li> <li>- 15 studies completed</li> </ul>	<ul style="list-style-type: none"> <li>- Condom audits</li> <li>- KAP studies</li> <li>- Project reports</li> </ul>	<ul style="list-style-type: none"> <li>- NGOs will work in AIDS prevention</li> <li>- Relative economic stability</li> <li>- Continued functioning of a commercial condom distribution system</li> <li>- Ability/willingness to pay for condoms</li> </ul>
<p><b>Project Inputs:</b></p> <ul style="list-style-type: none"> <li>• Administration \$1,342,000</li> <li>• Grants to NGOs \$5,000,000</li> <li>• Support to NGOs \$2,883,000</li> <li>• Research \$435,000</li> <li>• Evaluation &amp; Audits \$340,000</li> <li><b>TOTAL \$10,000,000</b></li> </ul>		<ul style="list-style-type: none"> <li>- Financial reports</li> <li>- Audits</li> </ul>	<ul style="list-style-type: none"> <li>- USAID support to APAC continues</li> <li>- Inputs are available on a timely basis</li> </ul>

D.O. No. 2(16)-AID/89  
भारत सरकार Government of India  
वित्त मंत्रालय Ministry of Finance  
आर्थिक कार्य विभाग Department of Economic Affairs



SUMATI MEHTA  
DY. SECRETARY (AC)  
TEL. NO. 3014443

नई दिल्ली / New Delhi, 28th Oct. 1993

Dear Mr. Mahoney,

This is to confirm our request for assistance for the following three projects :-

1. Innovations in Family Planning Services;
2. AIDS Prevention and Control;
3. Trade in Environmental Services and Technologies

With regards,

Yours sincerely,

  
(SUMATI MEHTA)

Mr. Timothy M. Mahoney  
Director  
Program Development and Project Support  
USAID  
American Embassy  
New Delhi.

PHONE: { 2352018 2352123  
2352371**THE VOLUNTARY HEALTH SERVICES**

ADYAR MADRAS 600 113

MANAGING TRUSTEE :  
SRI M. A. CHIDAMBARAMSECRETARY :  
Dr. N.S. MURALIDIRECTOR OF PROJECT :  
Dr. K.S. SANJIVIPRESIDENT :  
Dr. N. MAHALINGAMTREASURER :  
SRI M. SUBRAMANIAM

Ref. No...VHS/AIDS/92..

Date..6th..May..1992..

Dr.Ms.Constance A. Carrino  
Chief  
Biomedical Research & Technology  
Office of Health, Population & Nutrition  
United States Agency for International Development  
D/28, Institutional Area, Qutab Hotel Road  
New Delhi - 110 016

Dear Dr. Constance A. Carrino,

Thank you for your kind letter dated 16th April'92. Vide our letter No.VHS/AIDS/92 dated 1st May'92 we had enclosed the annual reports for the last three years. Please also refer to the discussions Dr. Rao and I had with Dr.Philip Thomas at Madras and further discussions Dr. Rao had with Dr. Philip Thomas on 5th May.

The Voluntary Health Services is looking forward to work with the USAID/Government of India and the Government of Tamil Nadu as well as with the Voluntary Organisations in the State in the innovative AIDS Prevention and Control Project. Such a project is not only essential but also very timely for prevention of the spread of the deadly disease.

At a recent meeting of the Board of VHS the possible involvement of VHS was discussed. The discussion clearly indicated that the Central Committee (Board) felt that VHS involvement in this activity was in keeping with its objectives and would be a path breaking effort for maintaining and promoting the health gains that have accrued to the people of Tamil Nadu.

Based on VHS's past experience with USAID, especially through the PVOH I project we are sure that a satisfactory working relationship will be maintained and that through this project the NGO sector's involvement with primary health care will be greatly expanded and strengthened.

.... 2

Recd 5/11/92

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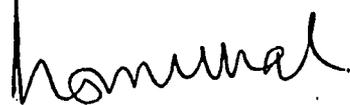
.. 2 ..

We hope it will be possible to work together on this important activity.

Please do not hesitate to ask us for any clarifications in this regard.

With best regards,

Yours sincerely,



DR. N. S. MURALI  
SECRETARY

1s/-

STATUTORY CHECKLISTS

**5C(1) - COUNTRY CHECKLIST**

Listed below are statutory criteria applicable to the eligibility of countries to receive the following categories of assistance: (A) both Development Assistance and Economic Support Funds; (B) Development Assistance funds only; or (C) Economic Support Funds only.

**A. COUNTRY ELIGIBILITY CRITERIA APPLICABLE TO BOTH DEVELOPMENT ASSISTANCE AND ECONOMIC SUPPORT FUND ASSISTANCE**

**1. Narcotics**

a. **Negative certification** (FY 1991 Appropriations Act Sec. 559(b)): Has the President certified to the Congress that the government of the recipient country is failing to take adequate measures to prevent narcotic drugs or other controlled substances which are cultivated, produced or processed illicitly, in whole or in part, in such country or transported through such country, from being sold illegally within the jurisdiction of such country to United States Government personnel or their dependents or from entering the United States unlawfully?

NO

b. **Positive certification** (FAA Sec. 481(h)). (This provision applies to assistance of any kind provided by grant, sale, loan, lease, credit, guaranty, or insurance, except assistance from the Child Survival Fund or relating to international narcotics control, disaster and refugee relief, narcotics education and awareness, or the provision of food or medicine.) If the recipient is a "major illicit drug producing country" (defined as a country producing during a fiscal year at least five metric tons of opium or 500 metric tons of coca or marijuana) or a "major drug-transit country" (defined as a country that is a significant direct

N/A

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source of illicit drugs significantly affecting the United States, through which such drugs are transported, or through which significant sums of drug-related profits are laundered with the knowledge or complicity of the government):

(1) does the country have in place a bilateral narcotics agreement with the United States, or a multilateral narcotics agreement?

(2) has the President in the March 1 International Narcotics Control Strategy Report (INSCR) determined and certified to the Congress (without Congressional enactment, within 45 days of continuous session, of a resolution disapproving such a certification), or has the President determined and certified to the Congress on any other date (with enactment by Congress of a resolution approving such certification), that (a) during the previous year the country has cooperated fully with the United States or taken adequate steps on its own to satisfy the goals agreed to in a bilateral narcotics agreement with the United States or in a multilateral agreement, to prevent illicit drugs produced or processed in or transported through such country from being transported into the United States, to prevent and punish drug profit laundering in the country, and to prevent and punish bribery and other forms of public corruption which facilitate production or shipment of illicit drugs or discourage prosecution of such acts, or that (b) the vital national interests of the United States require the provision of such assistance?

c. Government Policy (1986 Anti-Drug Abuse Act of 1986 Sec. 2013(b)). (This section applies to the same categories of assistance subject to the restrictions in FAA Sec. 481(h), above.) If recipient country is a "major illicit drug producing country" or "major drug-transit country" (as defined for the purpose of FAA Sec 481(h)), has the President submitted a report to Congress

N/A

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listing such country as one: (a) which, as a matter of government policy, encourages or facilitates the production or distribution of illicit drugs; (b) in which any senior official of the government engages in, encourages, or facilitates the production or distribution of illegal drugs; (c) in which any member of a U.S. Government agency has suffered or been threatened with violence inflicted by or with the complicity of any government officer; or (d) which fails to provide reasonable cooperation to lawful activities of U.S. drug enforcement agents, unless the President has provided the required certification to Congress pertaining to U.S. national interests and the drug control and criminal prosecution efforts of that country?

2. **Indebtedness to U.S. citizens** (FAA Sec. 620(c): If assistance is to a government, is the government indebted to any U.S. citizen for goods or services furnished or ordered where: (a) such citizen has exhausted available legal remedies, (b) the debt is not denied or contested by such government, or (c) the indebtedness arises under an unconditional guaranty of payment given by such government or controlled entity?

NO

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

NO

4. **Communist countries** (FAA Secs. 620(a), 620(f), 620D; FY 1991 Appropriations Act Secs. 512, 545): Is recipient country a Communist country? If so, has the President: (a) determined that assistance to the country is vital to the security of the United States, that the recipient country is not controlled by

NO

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the international Communist conspiracy, and that such assistance will further promote the independence of the recipient country from international communism, or (b) removed a country from applicable restrictions on assistance to communist countries upon a determination and report to Congress that such action is important to the national interest of the United States? Will assistance be provided either directly or indirectly to Angola, Cambodia, Cuba, Iraq, Libya, Vietnam, Iran or Syria? Will assistance be provided to Afghanistan without a certification, or will assistance be provided inside Afghanistan through the Soviet-controlled government of Afghanistan?

5. **Mob Action (FAA Sec. 620(j)):** NO  
Has the country permitted, or failed to take adequate measures to prevent, damage or destruction by mob action of U.S. property?-

6. **OPIC Investment Guaranty (FAA Sec. 620(l)):** NO  
Has the country failed to enter into an investment guaranty agreement with OPIC?

7. **Seizure of U.S. Fishing Vessels (FAA Sec. 620(o); Fishermen's Protective Act of 1967 (as amended) Sec. 5):** (a) NO  
(a) Has the country seized, or imposed any penalty or sanction against, any U.S. fishing vessel because of fishing activities in international waters? (b) If so, has any deduction required by the Fishermen's Protective Act been made? (b) N/A

8. **Loan Default (FAA Sec. 620(q); FY 1991 Appropriations Act Sec. 518 (Brooke Amendment)):** (a) NO  
(a) Has the government of the recipient country been in default for more than six months on interest or principal of any loan to the country under the FAA? (b) NO  
(b) Has the country been in default for more than one year on interest or principal on any U.S. loan under a program for which the FY 1990 Appropriations Act appropriates funds?

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**9. Military Equipment (FAA Sec. 620(s)):** If contemplated assistance is development loan or to come from Economic Support Fund, has the Administrator taken into account the percentage of the country's budget and amount of the country's foreign exchange or other resources spent on military equipment? (Reference may be made to the annual "Taking Into Consideration" memo: "Yes, taken into account by the Administrator at time of approval of Agency OYB." This approval by the Administrator of the Operational Year Budget can be the basis for an affirmative answer during the fiscal year unless significant changes in circumstances occur.)

N/A

**10. Diplomatic Relations with U.S. (FAA Sec. 620(t)):** Has the country severed diplomatic relations with the United States? If so, have relations been resumed and have new bilateral assistance agreements been negotiated and entered into since such resumption?

NO

**11. U.N. Obligations (FAA Sec. 620(u)):** What is the payment status of the country's U.N. obligations? If the country is in arrears, were such arrearages taken into account by the A.I.D. Administrator in determining the current A.I.D. Operational Year Budget? (Reference may be made to the "Taking into Consideration" memo.)

India is in arrears but this has been taken into account by the Administrator at time of approval of Agency OYB

**12. International Terrorism**

**a. Sanctuary and support (FY 1991 Appropriations Act Sec. 556; FAA Sec. 620A):** Has the country been determined by the President to: (a) grant sanctuary from prosecution to any individual or group which has committed an act of international terrorism, or (b) otherwise support international terrorism, unless the President has waived this restriction on grounds of national security or for humanitarian reasons?

(a) NO

(b) NO

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b. **Airport Security** (ISDCA of 1985 Sec. 552(b)). Has the Secretary of State determined that the country is a high terrorist threat country after the Secretary of Transportation has determined, pursuant to section 1115(e)(2) of the Federal Aviation Act of 1958, that an airport in the country does not maintain and administer effective security measures?

NO

13. **Discrimination** (FAA Sec. 666(b)): Does the country object, on the basis of race, religion, national origin or sex, to the presence of any officer or employee of the U.S. who is present in such country to carry out economic development programs under the FAA?

NO

14. **Nuclear Technology** (FAA Secs. 669, 670): Has the country, after August 3, 1977, delivered to any other country or received nuclear enrichment or reprocessing equipment, materials, or technology, without specified arrangements or safeguards, and without special certification by the President? Has it transferred a nuclear explosive device to a non-nuclear weapon state, or if such a state, either received or detonated a nuclear explosive device? If the country is a non-nuclear weapon state, has it, on or after August 8, 1985, exported (or attempted to export) illegally from the United States any material, equipment, or technology which would contribute significantly to the ability of a country to manufacture a nuclear explosive device? (FAA Sec. 620E permits a special waiver of Sec. 669 for Pakistan.)

No such action is known to have occurred

15. **Algiers Meeting** (ISDCA of 1981, Sec. 720): Was the country represented at the Meeting of Ministers of Foreign Affairs and Heads of Delegations of the Non-Aligned Countries to the 36th General Assembly of the U.N. on Sept. 25 and 28, 1981, and did it fail to disassociate itself from the communique issued? If so, has the President taken it into account? (Reference may be made to the "Taking into Consideration" memo.)

Although India was represented and failed to disassociate itself from the communique, this factor was taken into account by the Administrator at the time of approval of the Agency OYB.

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16. **Military Coup (FY 1991 Appropriations Act Sec. 513):** Has the duly elected Head of Government of the country been deposed by military coup or decree? If assistance has been terminated, has the President notified Congress that a democratically elected government has taken office prior to the resumption of assistance? NO

17. **Refugee Cooperation (FY 1991 Appropriations Act Sec. 539):** Does the recipient country fully cooperate with the international refugee assistance organizations, the United States, and other governments in facilitating lasting solutions to refugee situations, including resettlement without respect to race, sex, religion, or national origin? YES

18. **Exploitation of Children (FY 1991 Appropriations Act Sec. 599D, amending FAA Sec. 116):** Does the recipient government fail to take appropriate and adequate measures, within its means, to protect children from exploitation, abuse or forced conscription into military or paramilitary services? NO

B. **COUNTRY ELIGIBILITY CRITERIA APPLICABLE ONLY TO DEVELOPMENT ASSISTANCE ("DA")**

1. **Human Rights Violations (FAA Sec. 116):** Has the Department of State determined that this government has engaged in a consistent pattern of gross violations of internationally recognized human rights? If so, can it be demonstrated that contemplated assistance will directly benefit the needy? NO

2. **Abortions (FY 1991 Appropriations Act Sec. 535):** Has the President certified that use of DA funds by this country would violate any of the prohibitions against use of funds to pay for the performance of abortions as a method of family planning, to motivate or coerce any person to practice abortions, to pay for the performance of involuntary NO

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sterilization as a method of family planning, to coerce or provide any financial incentive to any person to undergo sterilizations, to pay for any biomedical research which relates, in whole or in part, to methods of, or the performance of, abortions or involuntary sterilization as a means of family planning?

C. COUNTRY ELIGIBILITY CRITERIA APPLICABLE ONLY TO ECONOMIC SUPPORT FUNDS ("ESF")

Human Rights Violations (FAA Sec. 502B): Has it been determined that the country has engaged in a consistent pattern of gross violations of internationally recognized human rights? If so, has the President found that the country made such significant improvement in its human rights record that furnishing such assistance is in the U.S. national interest?

N/A

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**5C(2) - ASSISTANCE CHECKLIST**

Listed below are statutory criteria applicable to the assistance resources themselves, rather than to the eligibility of a country to receive assistance. This section is divided into three parts. Part A includes criteria applicable to both Development Assistance and Economic Support Fund resources. Part B includes criteria applicable only to Development Assistance resources. Part C includes criteria applicable only to Economic Support Funds.

CROSS REFERENCE: IS COUNTRY CHECKLIST UP TO DATE?

**A. CRITERIA APPLICABLE TO BOTH DEVELOPMENT ASSISTANCE AND ECONOMIC SUPPORT FUNDS**

**1. Host Country Development Efforts**  
(FAA Sec. 601(a)): Information and conclusions on whether assistance 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.

**2. U.S. Private Trade and Investment**  
(FAA Sec. 601(b)): Information and conclusions on how assistance 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).

cooperatives

- (a) No effect
- (b) Most of assistance will be administered through non-governmental organizations which will gain experience in fostering the prevention and control of AIDS.
- (c) As non-governmental organizations -/ credit unions and savings and loan institutions might elect to apply for grants under the project, joining the effort to prevent and control AIDS.
- (d) No effect
- (e) No effect
- (f) No effect

Project will have little or no effect on U.S. private trade and investment abroad.

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### 3. Congressional Notification

a. **General requirement (FY 1991 Appropriations Act Secs. 523 and 591; FAA Sec. 634A):** If money is to be obligated for an activity not previously justified to Congress, or for an amount in excess of amount previously justified to Congress, has Congress been properly notified (unless the notification requirement has been waived because of substantial risk to human health or welfare)?

YES

b. **Notice of new account obligation (FY 1991 Appropriations Act Sec. 514):** If funds are being obligated under an appropriation account to which they were not appropriated, has the President consulted with and provided a written justification to the House and Senate Appropriations Committees and has such obligation been subject to regular notification procedures?

N/A

c. **Cash transfers and nonproject sector assistance (FY 1991 Appropriations Act Sec. 575(b)(3)):** If funds are to be made available in the form of cash transfer or nonproject sector assistance, has the Congressional notice included a detailed description of how the funds will be used, with a discussion of U.S. interests to be served and a description of any economic policy reforms to be promoted?

N/A

4. **Engineering and Financial Plans (FAA Sec. 611(a)):** Prior to an obligation in excess of \$500,000, will there be: (a) engineering, financial or other plans necessary to carry out the assistance; and (b) a reasonably firm estimate of the cost to the U.S. of the assistance?

(a) YES

(b) YES

5. **Legislative Action (FAA Sec. 611(a)(2)):** If legislative action is required within recipient country with respect to an obligation in excess of \$500,000, what is the basis for a reasonable expectation that such action

Legislative action is not required.

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will be completed in time to permit orderly accomplishment of the purpose of the assistance?

6. **Water Resources** (FAA Sec. 611(b); FY 1991 Appropriations Act Sec. 501): If project is for water or water-related land resource construction, have benefits and costs been computed to the extent practicable in accordance with the principles, standards, and procedures established pursuant to the Water Resources Planning Act (42 U.S.C. 1962, et seq.)? (See A.I.D. Handbook 3 for guidelines.)

N/A

7. **Cash Transfer and Sector Assistance** (FY 1991 Appropriations Act Sec. 575(b)): Will cash transfer or nonproject sector assistance be maintained in a separate account and not commingled with other funds (unless such requirements are waived by Congressional notice for nonproject sector assistance)?

N/A

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

N/A

9. **Multiple Country Objectives** (FAA Sect 601(a)): Information and conclusions on whether projects 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.

See response to paragraph in this part A of the checklist

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10. **U.S. Private Trade** (FAA Sec. 601(b)): Information and conclusions 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).

Project will have little or no effect on U.S. private trade and investment abroad

11. **Local Currencies**

a. **Recipient Contributions** (FAA Secs. 612(b), 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 in lieu of dollars.

The Indian contribution to the project will be commodities provided in support of the project's objective rather than local currency to meet the cost of contractual and other services. No foreign currencies owned by the U.S. are available.

b. **U.S.-Owned Currency** (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?

NO

c. **Separate Account** (FY 1991 Appropriations Act Sec. 575). If assistance is furnished to a foreign government under arrangements which result in the generation of local currencies:

N/A

(1) Has A.I.D. (a) required that local currencies be deposited in a separate account established by the recipient government, (b) entered into an agreement with that government providing the amount of local currencies to be generated and the terms and conditions under which the currencies so deposited may be utilized, and (c) established by agreement the responsibilities of A.I.D. and that government to monitor and account for deposits into and disbursements from the separate account?

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(2) Will such local currencies, or an equivalent amount of local currencies, be used only to carry out the purposes of the DA or ESF chapters of the FAA (depending on which chapter is the source of the assistance) or for the administrative requirements of the United States Government?

(3) Has A.I.D. taken all appropriate steps to ensure that the equivalent of local currencies disbursed from the separate account are used for the agreed purposes?

(4) If assistance is terminated to a country, will any unencumbered balances of funds remaining in a separate account be disposed of for purposes agreed to by the recipient government and the United States Government?

## 12. Trade Restrictions

a. Surplus Commodities (FY 1991 Appropriations Act Sec. 521(a)): If assistance is for the production of any commodity for export, is the commodity likely to be in surplus on world markets at the time the resulting productive capacity becomes operative, and is such assistance likely to cause substantial injury to U.S. producers of the same, similar or competing commodity?

N/A

b. Textiles (Lautenberg Amendment) (FY 1991 Appropriations Act Sec. 521(c)): Will the assistance (except for programs in Caribbean Basin Initiative countries under U.S. Tariff Schedule "Section 807," which allows reduced tariffs on articles assembled abroad from U.S.-made components) be used directly to procure feasibility studies, prefeasibility studies, or project profiles of potential investment in, or to assist the establishment of facilities specifically designed for, the manufacture for export to the United States or to third country markets in direct competition with U.S. exports, of

NO

JK

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textiles, apparel, footwear, handbags, flat goods (such as wallets or coin purses worn on the person), work gloves or leather wearing apparel?

13. **Tropical Forests (FY 1991 Appropriations Act Sec. 533(c)(3)):** Will funds be used for any program, project or activity which would (a) result in any significant loss of tropical forests, or (b) involve industrial timber extraction in primary tropical forest areas?

NO

14. **PVO Assistance**

a. **Auditing and registration (FY 1991 Appropriations Act Sec. 537):** If assistance is being made available to a PVO, has that organization provided upon timely request any document, file, or record necessary to the auditing requirements of A.I.D., and is the PVO registered with A.I.D.?

N/A

b. **Funding sources (FY 1991 Appropriations Act, Title II, under heading "Private and Voluntary Organizations"):** If assistance is to be made to a United States PVO (other than a cooperative development organization), does it obtain at least 20 percent of its total annual funding for international activities from sources other than the United States Government?

N/A

15. **Project Agreement Documentation (State Authorization Sec. 139 (as interpreted by conference report)):** Has confirmation of the date of signing of the project agreement, including the amount involved, been cabled to State L/T and A.I.D. LEG within 60 days of the agreement's entry into force with respect to the United States, and has the full text of the agreement been pouched to those same offices? (See Handbook 3, Appendix 6G for agreements covered by this provision).

The aggregate amount of assistance being provided is less than \$25 million; therefore this requirement is not applicable

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**16. Metric System** (Omnibus Trade and Competitiveness Act of 1988 Sec. 5164, as interpreted by conference report, amending Metric Conversion Act of 1975 Sec. 2, and as implemented through A.I.D. policy):

Does the assistance activity use the metric system of measurement in its procurements, grants, and other business-related activities, except to the extent that such use is impractical or is likely to cause significant inefficiencies or loss of markets to United States firms? Are bulk purchases usually to be made in metric, and are components, subassemblies, and semi-fabricated materials to be specified in metric units when economically available and technically adequate? Will A.I.D. specifications use metric units of measure from the earliest programmatic stages, and from the earliest documentation of the assistance processes (for example, project papers) involving quantifiable measurements (length, area, volume, capacity, mass and weight), through the implementation stage?

To the extent practicable, metric measurements will be used in all procurements, grants and other activities under the Project.

**17. Women in Development** (FY 1991 Appropriations Act, Title II, under heading "Women in Development"): Will assistance be designed so that the percentage of women participants will be demonstrably increased?

YES

**18. Regional and Multilateral Assistance** (FAA Sec. 209): Is assistance more efficiently and effectively provided through regional or multilateral organizations? If so, why is assistance not so provided? Information and conclusions on whether assistance will encourage developing countries to cooperate in regional development programs.

Other Bilateral and multilateral donors are providing assistance for AIDS prevention and control on a broad national basis or for specific activities. The A.I.D. project will target a specific element of the population at risk to HIV infection in one Indian State.

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**19. Abortions (FY 1991 Appropriations Act, Title II, under heading "Population, DA," and Sec. 525):**

a. Will assistance be made available to any organization or program which, as determined by the President, supports or participates in the management of a program of coercive abortion or involuntary sterilization? NO

b. Will any funds be used to lobby for abortion? NO

**20. Cooperatives (FAA Sec. 111):** Will assistance help develop cooperatives, especially by technical assistance, to assist rural and urban poor to help themselves toward a better life? NO

**21. U.S.-Owned Foreign Currencies**

a. Use of currencies (FAA Secs. 612(b), 636(h); FY 1991 Appropriations Act Secs. 507, 509): Describe steps taken to assure that, to the maximum extent possible, foreign currencies owned by the U.S. are utilized in lieu of dollars to meet the cost of contractual and other services. See the response to para 11 a above

b. Release of currencies (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? NO

**22. Procurement**

a. Small business (FAA Sec. 602(a)): Are there arrangements to permit U.S. small business to participate equitably in the furnishing of commodities and services financed? Procurement opportunities will be advertised publicly, including in AID publication aimed at small businesses

b. U.S. procurement (FAA Sec. 604(a)): Will all procurement be from the U.S. except as otherwise determined by the President or determined under delegation from him? YES

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**c. Marine insurance (FAA Sec. 604(d)):** If the cooperating country discriminates against marine insurance companies authorized to do business in the U.S., will commodities be insured in the United States against marine risk with such a company? N/A

**d. Non-U.S. agricultural procurement (FAA Sec. 604(e)):** If non-U.S. procurement of agricultural commodity or product thereof is to be financed, is there provision against such procurement when the domestic price of such commodity is less than parity? (Exception where commodity financed could not reasonably be procured in U.S.) N/A

**e. Construction or engineering services (FAA Sec. 604(g)):** Will construction or engineering services be procured from firms of advanced developing countries which are otherwise eligible under Code 941 and which have attained a competitive capability in international markets in one of these areas? (Exception for those countries which receive direct economic assistance under the FAA and permit United States firms to compete for construction or engineering services financed from assistance programs of these countries.) NO

**f. Cargo preference shipping (FAA Sec. 603):** Is the shipping excluded from compliance with the requirement in section 901(b) of the Merchant Marine Act of 1936, as amended, that at least 50 percent of the gross tonnage of commodities (computed separately for dry bulk carriers, dry cargo liners, and tankers) financed shall be transported on privately owned U.S. flag commercial vessels to the extent such vessels are available at fair and reasonable rates? NO

**g. Technical assistance (FAA Sec. 621(a)):** If technical assistance is financed, will such assistance be furnished by private enterprise on a contract basis to the fullest extent practicable? Will the YES, YES

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facilities and resources of other Federal agencies be utilized, when they are particularly suitable, not competitive with private enterprise, and made available without undue interference with domestic programs?

**h. U.S. air carriers**  
(International Air Transportation Fair Competitive Practices Act, 1974): If air transportation of persons or property is financed on grant basis, will U.S. carriers be used to the extent such service is available?

YES

**i. Termination for convenience of U.S. Government** (FY 1991 Appropriations Act Sec. 504): If the U.S. Government is a party to a contract for procurement, does the contract contain a provision authorizing termination of such contract for the convenience of the United States?

YES

**j. Consulting services**  
(FY 1991 Appropriations Act Sec. 524): If assistance is for consulting service through procurement contract pursuant to 5 U.S.C. 3109, are contract expenditures a matter of public record and available for public inspection (unless otherwise provided by law or Executive order)?

YES

**k. Metric conversion**  
(Omnibus Trade and Competitiveness Act of 1988, as interpreted by conference report, amending Metric Conversion Act of 1975 Sec. 2, and as implemented through A.I.D. policy): Does the assistance program use the metric system of measurement in its procurements, grants, and other business-related activities, except to the extent that such use is impractical or is likely to cause significant inefficiencies or loss of markets to United States firms? Are bulk purchases usually to be made in metric, and are components, subassemblies, and semi-fabricated materials to be specified in metric units when economically available and technically adequate? Will A.I.D. specifications use metric units of measure from the earliest programmatic stages, and from the earliest

Metric measurements are used to the maximum extent practicable under the USAID India assistance program. No bulk purchases are contemplated under the project. Where measurements are included in project design documentation and measurements are stated in metric units unless impracticable

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documentation of the assistance processes (for example, project papers) involving quantifiable measurements (length, area, volume, capacity, mass and weight), through the implementation stage?

1. **Competitive Selection Procedures** (FAA Sec. 601(e)): Will the assistance utilize competitive selection procedures for the awarding of contracts, except where applicable procurement rules allow otherwise?

YES

23. **Construction**

N/A

a. **Capital project** (FAA Sec. 601(d)): If capital (e.g., construction) project, will U.S. engineering and professional services be used?

b. **Construction contract** (FAA Sec. 611(c)): If contracts for construction are to be financed, will they be let on a competitive basis to maximum extent practicable?

c. **Large projects, Congressional approval** (FAA Sec. 620(k)): If for construction of productive enterprise, will aggregate value of assistance to be furnished by the U.S. not exceed \$100 million (except for productive enterprises in Egypt that were described in the Congressional Presentation), or does assistance have the express approval of Congress?

24. **U.S. Audit Rights** (FAA Sec. 301(d)): If fund is established solely by U.S. contributions and administered by an international organization, does Comptroller General have audit rights?

N/A

25. **Communist Assistance** (FAA Sec. 620(h)). Do arrangements exist to insure that United States foreign aid is not used in a manner which, contrary to the best interests of the United States, promotes or assists the foreign aid projects or activities of the Communist-bloc countries?

YES

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**26. Narcotics**

a. **Cash reimbursements (FAA Sec. 483):** Will arrangements preclude use of financing to make reimbursements, in the form of cash payments, to persons whose illicit drug crops are eradicated? YES

b. **Assistance to narcotics traffickers (FAA Sec. 487):** Will arrangements take "all reasonable steps" to preclude use of financing to or through individuals or entities which we know or have reason to believe have either: (1) been convicted of a violation of any law or regulation of the United States or a foreign country relating to narcotics (or other controlled substances); or (2) been an illicit trafficker in, or otherwise involved in the illicit trafficking of, any such controlled substance? YES

27. **Expropriation and Land Reform (FAA Sec. 620(g)):** Will assistance preclude use of financing to compensate owners for expropriated or nationalized property, except to compensate foreign nationals in accordance with a land reform program certified by the President? YES

28. **Police and Prisons (FAA Sec. 660):** Will assistance preclude use of financing to provide training, advice, or any financial support for police, prisons, or other law enforcement forces, except for narcotics programs? YES

29. **CIA Activities (FAA Sec. 662):** Will assistance preclude use of financing for CIA activities? YES

30. **Motor Vehicles (FAA Sec. 636(i)):** Will assistance preclude use of financing for purchase, sale, long-term lease, exchange or guaranty of the sale of motor vehicles manufactured outside U.S., unless a waiver is obtained? YES

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31. **Military Personnel (FY 1991 Appropriations Act Sec. 503):** Will assistance preclude use of financing to pay pensions, annuities, retirement pay, or adjusted service compensation for prior or current military personnel? YES

32. **Payment of U.N. Assessments (FY 1991 Appropriations Act Sec. 505):** Will assistance preclude use of financing to pay U.N. assessments, arrearages or dues? YES

33. **Multilateral Organization Lending (FY 1991 Appropriations Act Sec. 506):** Will assistance preclude use of financing to carry out provisions of FAA section 209(d) (transfer of FAA funds to multilateral organizations for lending)? YES

34. **Export of Nuclear Resources (FY 1991 Appropriations Act Sec. 510):** Will assistance preclude use of financing to finance the export of nuclear equipment, fuel, or technology? YES

35. **Repression of Population (FY 1991 Appropriations Act Sec. 511):** Will assistance preclude use of financing for the purpose of aiding the efforts of the government of such country to repress the legitimate rights of the population of such country contrary to the Universal Declaration of Human Rights? YES

36. **Publicity or Propoganda (FY 1991 Appropriations Act Sec. 516):** Will assistance be used for publicity or propoganda purposes designed to support or defeat legislation pending before Congress, to influence in any way the outcome of a political election in the United States, or for any publicity or propoganda purposes not authorized by Congress? NO

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37. **Marine Insurance (FY 1991 Appropriations Act Sec. 563):** Will any A.I.D. contract and solicitation, and subcontract entered into under such contract, include a clause requiring that U.S. marine insurance companies have a fair opportunity to bid for marine insurance when such insurance is necessary or appropriate?

YES

38. **Exchange for Prohibited Act (FY 1991 Appropriations Act Sec. 569):** Will any assistance be provided to any foreign government (including any instrumentality or agency thereof), foreign person, or United States person in exchange for that foreign government or person undertaking any action which is, if carried out by the United States Government, a United States official or employee, expressly prohibited by a provision of United States law?

NO

B. **CRITERIA APPLICABLE TO DEVELOPMENT ASSISTANCE ONLY**

1. **Agricultural Exports (Bumpers Amendment) (FY 1991 Appropriations Act Sec. 521(b), as interpreted by conference report for original enactment):** If assistance is for agricultural development activities (specifically, any testing or breeding feasibility study, variety improvement or introduction, consultancy, publication, conference, or training), are such activities: (1) specifically and principally designed to increase agricultural exports by the host country to a country other than the United States, where the export would lead to direct competition in that third country with exports of a similar commodity grown or produced in the United States, and can the activities reasonably be expected to cause substantial injury to U.S. exporters of a similar agricultural commodity; or (2) in support of research that is intended primarily to benefit U.S. producers?

N/A

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2. **Tied Aid Credits (FY 1991 Appropriations Act, Title II, under heading "Economic Support Fund"):** Will DA funds be used for tied aid credits?

NO

3. **Appropriate Technology (FAA Sec. 107):** Is special emphasis placed on use of appropriate technology (defined as relatively smaller, cost-saving, labor-using technologies that are generally most appropriate for the small farms, small businesses, and small incomes of the poor)?

Yes..The use of condoms will be promoted amongst those most at risk to HIV infection: prostitutes and their clients and STD patients. Such persons are generally among the poorest segment of the population for whom HIV infection can be most economically devastating.

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

The project recognizes the need for protection of the people against sexually transmitted diseases. It will involve NGOs in a major national health program of the GOI.

5. **Economic Development (FAA Sec. 101(a)):** Does the activity give reasonable promise of contributing to the development of economic resources, or to the increase of productive capacities and self-sustaining economic growth?

Yes..The project will reduce the incidence of diseases which reduce the working capacity of the economically active population.

6. **Special Development Emphases (FAA Secs. 102(b), 113, 281(a)):** Describe 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, dispersing investment from cities to small towns and rural areas, and insuring wide participation of the poor in the benefits of development on a sustained basis, using appropriate U.S. institutions; (b) 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

(a) The project will extend the geographic and demographic reach of the GOIs National Strategic Plan for the Prevention and Control of AIDS in India, seeking out groups at the highest risk of HIV infection. Among these groups are the poor and low paid workers in rural areas.  
(b) The project will encourage NGOs to join in support of a major governmental program.  
(c) It supports a GOI priority program  
(d) It will reduce the incidence of HIV infection among women enabling them to participate more fully in the national economy.  
(e) It will set an example of national-state level cooperation in attacking a development problem.

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and the improvement of women's status; and  
(e) utilize and encourage regional  
cooperation by developing countries.

7. **Recipient Country Contribution** (FAA Secs. 110, 124(d)): Will the recipient country provide at least 25 percent of the costs of the program, project, or activity with respect to which the assistance is to be furnished (or is the latter cost-sharing requirement being waived for a "relatively least developed" country)? YES

8. **Benefit to Poor Majority** (FAA Sec. 128(b)): If the activity attempts to increase the institutional capabilities of private organizations or the government of the country, or if it attempts to stimulate scientific and technological research, has it been designed and will it be monitored to ensure that the ultimate beneficiaries are the poor majority? YES

9. **Abortions** (FAA Sec. 104(f); FY 1991 Appropriations Act, Title II, under heading "Population, DA," and Sec. 535):

a. Are any of the funds to be used for the performance of abortions as a method of family planning or to motivate or coerce any person to practice abortions? NO

b. Are any of the funds to be used to pay for the performance of involuntary sterilization as a method of family planning or to coerce or provide any financial incentive to any person to undergo sterilizations? NO

c. Are any of the funds to be made available to any organization or program which, as determined by the President, supports or participates in the management of a program of coercive abortion or involuntary sterilization? NO

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d. Will funds be made available only to voluntary family planning projects which offer, either directly or through referral to, or information about access to, a broad range of family planning methods and services? N/A

e. In awarding grants for natural family planning, will any applicant be discriminated against because of such applicant's religious or conscientious commitment to offer only natural family planning? NO

f. Are any of the funds to be used to pay for any biomedical research which relates, in whole or in part, to methods of, or the performance of, abortions or involuntary sterilization as a means of family planning? NO

g. Are any of the funds to be made available to any organization if the President certifies that the use of these funds by such organization would violate any of the above provisions related to abortions and involuntary sterilization? NO

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

11. Disadvantaged Enterprises (FY 1991 Appropriations Act Sec. 567): What portion of the funds will be available only for activities of economically and socially disadvantaged enterprises, historically black colleges and universities, colleges and universities having a student body in which more than 40 percent of the students are Hispanic Americans, and private and voluntary organizations which are controlled by individuals who are black Americans, Hispanic Americans, or Native Americans, or who are economically or socially disadvantaged (including women)? A specific portion of project funds has not been set aside for disadvantaged enterprises. However, if any contract for services in excess of \$500,00 is to be financed under the project, the USAID Mission will ensure that such contract contain a requirement for 10% of the contract to be sub contracted to disadvantaged enterprises unless AID regulations provide otherwise.

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12. **Biological Diversity (FAA Sec. 119(g):** Will the assistance: (a) support training and education efforts which improve the capacity of recipient countries to prevent loss of biological diversity; (b) be provided under a long-term agreement in which the recipient country agrees to protect ecosystems or other wildlife habitats; (c) support efforts to identify and survey ecosystems in recipient countries worthy of protection; or (d) by any direct or indirect means significantly degrade national parks or similar protected areas or introduce exotic plants or animals into such areas?

- (a) NO
- (b) NO
- (c) NO
- (d) NO

13. **Tropical Forests (FAA Sec. 118; FY 1991 Appropriations Act Sec. 533(c)-(e) & (g)):**

a. **A.I.D. Regulation 16:** Does the assistance comply with the environmental procedures set forth in A.I.D. Regulation 16?

YES

b. **Conservation:** Does the assistance place a high priority on conservation and sustainable management of tropical forests? Specifically, does the assistance, to the fullest extent feasible: (1) stress the importance of conserving and sustainably managing forest resources; (2) support activities which offer employment and income alternatives to those who otherwise would cause destruction and loss of forests, and help countries identify and implement alternatives to colonizing forested areas; (3) support training programs, educational efforts, and the establishment or strengthening of institutions to improve forest management; (4) help end destructive slash-and-burn agriculture by supporting stable and productive farming practices; (5) help conserve forests which have not yet been degraded by helping to increase production on lands already cleared or degraded; (6) conserve forested watersheds and rehabilitate those which have been deforested; (7) support training, research, and other actions

N/A

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which lead to sustainable and more environmentally sound practices for timber harvesting, removal, and processing; (8) support research to expand knowledge of tropical forests and identify alternatives which will prevent forest destruction, loss, or degradation; (9) conserve biological diversity in forest areas by supporting efforts to identify, establish, and maintain a representative network of protected tropical forest ecosystems on a worldwide basis, by making the establishment of protected areas a condition of support for activities involving forest clearance or degradation, and by helping to identify tropical forest ecosystems and species in need of protection and establish and maintain appropriate protected areas; (10) seek to increase the awareness of U.S. Government agencies and other donors of the immediate and long-term value of tropical forests; (11) utilize the resources and abilities of all relevant U.S. government agencies; (12) be based upon careful analysis of the alternatives available to achieve the best sustainable use of the land; and (13) take full account of the environmental impacts of the proposed activities on biological diversity?

c. **Forest degradation:** Will assistance be used for: (1) the procurement or use of logging equipment, unless an environmental assessment indicates that all timber harvesting operations involved will be conducted in an environmentally sound manner and that the proposed activity will produce positive economic benefits and sustainable forest management systems; (2) actions which will significantly degrade national parks or similar protected areas which contain tropical forests, or introduce exotic plants or animals into such areas; (3) activities which would result in the conversion of forest lands to the rearing of livestock; (4) the construction, upgrading, or maintenance of roads (including temporary haul roads for logging or other extractive industries) which pass through relatively undergraded

(1) NO

(2) NO

(3) NO

(4) NO

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forest lands; (5) the colonization of forest lands; or (6) the construction of dams or other water control structures which flood relatively undergraded forest lands, unless with respect to each such activity an environmental assessment indicates that the activity will contribute significantly and directly to improving the livelihood of the rural poor and will be conducted in an environmentally sound manner which supports sustainable development?

(5) NO  
(6) NO

d. **Sustainable forestry:** If assistance relates to tropical forests, will project assist countries in developing a systematic analysis of the appropriate use of their total tropical forest resources, with the goal of developing a national program for sustainable forestry?

N/A

e. **Environmental impact statements:** Will funds be made available in accordance with provisions of FAA Section 117(c) and applicable A.I.D. regulations requiring an environmental impact statement for activities significantly affecting the environment?

N/A

14. **Energy (FY 1991 Appropriations Act Sec. 533(c)):** If assistance relates to energy, will such assistance focus on: (a) end-use energy efficiency, least-cost energy planning, and renewable energy resources, and (b) the key countries where assistance would have the greatest impact on reducing emissions from greenhouse gases?

N/A

15. **Sub-Saharan Africa Assistance (FY 1991 Appropriations Act Sec. 562, adding a new FAA chapter 10 (FAA Sec. 496)):** If assistance will come from the Sub-Saharan Africa DA account, is it: (a) to be used to help the poor majority in Sub-Saharan Africa through a process of long-term development and economic growth that is equitable, participatory, environmentally sustainable, and self-reliant; (b) to be used to promote sustained economic growth, encourage

N/A

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private sector development, promote individual initiatives, and help to reduce the role of central governments in areas more appropriate for the private sector; (c) to be provided in a manner that takes into account, during the planning process, the local-level perspectives of the rural and urban poor, including women, through close consultation with African, United States and other PVOs that have demonstrated effectiveness in the promotion of local grassroots activities on behalf of long-term development in Sub-Saharan Africa; (d) to be implemented in a manner that requires local people, including women, to be closely consulted and involved, if the assistance has a local focus; (e) being used primarily to promote reform of critical sectoral economic policies, -or to support the critical sector priorities of agricultural production and natural resources, health, voluntary family planning services, education, and income generating opportunities; and (f) to be provided in a manner that, if policy reforms are to be effected, contains provisions to protect vulnerable groups and the environment from possible negative consequences of the reforms?

16. **Debt-for-Nature Exchange (FAA Sec. 463):** If project will finance a debt-for-nature exchange, describe how the exchange will support protection of: (a) the world's oceans and atmosphere, (b) animal and plant species, and (c) parks and reserves; or describe how the exchange will promote: (d) natural resource management, (e) local conservation programs, (f) conservation training programs, (g) public commitment to conservation, (h) land and ecosystem management, and (i) regenerative approaches in farming, forestry, fishing, and watershed management.

N/A

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**17. Deobligation/Reobligation**  
(FY 1991 Appropriations Act Sec. 515): If deob/reob authority is sought to be exercised in the provision of DA assistance, are the funds being obligated for the same general purpose, and for countries within the same region as originally obligated, and have the House and Senate Appropriations Committees been properly notified?

YES

**18. Loans**

**a. Repayment capacity** (FAA Sec. 122(b)): Information and conclusion on capacity of the country to repay the loan at a reasonable rate of interest.

N/A

**b. Long-range plans** (FAA Sec. 122(b)): Does the activity give reasonable promise of assisting long-range plans and programs designed to develop economic resources and increase productive capacities?

N/A

**c. Interest rate** (FAA Sec. 122(b)): If development loan is repayable in dollars, is interest rate at least 2 percent per annum during a grace period which is not to exceed ten years, and at least 3 percent per annum thereafter?

N/A

**d. Exports to United States**  
(FAA Sec. 620(d)): If assistance is for any productive enterprise which will compete with U.S. enterprises, is there an agreement by the recipient country to prevent export to the U.S. of more than 20 percent of the enterprise's annual production during the life of the loan, or has the requirement to enter into such an agreement been waived by the President because of a national security interest?

N/A

**19. Development Objectives** (FAA Secs. 102(a), 111, 113, 281(a)): Extent to which activity will: (1) effectively involve the poor in development, by expanding access to economy at local level, increasing labor-intensive production and the use of appropriate technology, spreading investment out from

N/A

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cities to small towns and rural areas, and insuring wide participation of the poor in the benefits of development on a sustained basis, using the appropriate U.S. institutions; (2) 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; (3) support the self-help efforts of developing countries; (4) promote the participation of women in the national economies of developing countries and the improvement of women's status; and (5) utilize and encourage regional cooperation by developing countries?

20. Agriculture, Rural Development and Nutrition, and Agricultural Research (FAA Secs. 103 and 103A):

N/A

a. Rural poor and small farmers: If assistance is being made available for agriculture, rural development or nutrition, describe extent to which activity is specifically designed to increase productivity and income of rural poor; or if assistance is being made available for agricultural research, has account been taken of the needs of small farmers, and extensive use of field testing to adapt basic research to local conditions shall be made.

b. Nutrition: Describe extent to which assistance is used in coordination with efforts carried out under FAA Section 104 (Population and Health) to help improve nutrition of the people of developing countries through encouragement of increased production of crops with greater nutritional value; improvement of planning, research, and education with respect to nutrition, particularly with reference to improvement and expanded use of indigenously produced foodstuffs; and the undertaking of pilot or demonstration programs explicitly addressing the problem of malnutrition of poor and vulnerable people.

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**c. Food security:** Describe extent to which activity increases national food security by improving food policies and management and by strengthening national food reserves, with particular concern for the needs of the poor, through measures encouraging domestic production, building national food reserves, expanding available storage facilities, reducing post harvest food losses, and improving food distribution.

N/A

**21. Population and Health (FAA Secs. 104(b) and (c)):** If assistance is being made available for population or health activities, describe 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 outreach.

The project will use population and health funds for activities which will reduce the incidence of HIV infection among the population most at risk: prostitutes and their clients and STD patients. To a large degree such people are among the society's poorest members. They will be reached by NGOs operating health and family planning clinics and community outreach programs. Commercial producers and distributors of condoms will be enlisted in the effort to reach the widest cross section of the population.

**22. Education and Human Resources Development (FAA Sec. 105):** If assistance is being made available for education, public administration, or human resource development, describe (a) extent to which activity strengthens nonformal education, makes formal education more relevant, especially for rural families and urban poor, and strengthens management capability of institutions enabling the poor to participate in development; and (b) extent to which assistance provides advanced education and training of people of developing countries in such disciplines as are required for planning and implementation of public and private development activities.

N/A

**23. Energy, Private Voluntary Organizations, and Selected Development Activities (FAA Sec. 106):** If assistance is being made available for energy, private voluntary organizations, and selected development problems, describe extent to which activity is:

N/A

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a. concerned with data collection and analysis, the training of skilled personnel, research on and development of suitable energy sources, and pilot projects to test new methods of energy production; and facilitative of research on and development and use of small-scale, decentralized, renewable energy sources for rural areas, emphasizing development of energy resources which are environmentally acceptable and require minimum capital investment;

b. concerned with technical cooperation and development, especially with U.S. private and voluntary, or regional and international development, organizations;

c. research into, and evaluation of, economic development processes and techniques;

d. reconstruction after natural or manmade disaster and programs of disaster preparedness;

e. for special development problems, and to enable proper utilization of infrastructure and related projects funded with earlier U.S. assistance;

f. for urban development, especially small, labor-intensive enterprises, marketing systems for small producers, and financial or other institutions to help urban poor participate in economic and social development.

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C. CRITERIA APPLICABLE TO ECONOMIC SUPPORT FUNDS ONLY

N/A

1. **Economic and Political Stability** (FAA Sec. 531(a)): Will this assistance promote economic and political stability? To the maximum extent feasible, is this assistance consistent with the policy directions, purposes, and programs of Part I of the FAA?

2. **Military Purposes** (FAA Sec. 531(e)): Will this assistance be used for military or paramilitary purposes?

3. **Commodity Grants/Separate Accounts** (FAA Sec. 609): If commodities are to be granted so that sale proceeds will accrue to the recipient country, have Special Account (counterpart) arrangements been made? (For FY 1991, this provision is superseded by the separate account requirements of FY 1991 Appropriations Act Sec. 575(a), see Sec. 575(a)(5).)

4. **Generation and Use of Local Currencies** (FAA Sec. 531(d)): Will ESF funds made available for commodity import programs or other program assistance be used to generate local currencies? If so, will at least 50 percent of such local currencies be available to support activities consistent with the objectives of FAA sections 103 through 106? (For FY 1991, this provision is superseded by the separate account requirements of FY 1991 Appropriations Act Sec. 575(a), see Sec. 575(a)(5).)

5. **Cash Transfer Requirements** (FY 1991 Appropriations Act, Title II, under heading "Economic Support Fund," and Sec. 575(b)). If assistance is in the form of a cash transfer:

a. **Separate account:** Are all such cash payments to be maintained by the country in a separate account and not to be commingled with any other funds?

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b. **Local currencies:** Will all local currencies that may be generated with funds provided as a cash transfer to such a country also be deposited in a special account, and has A.I.D. entered into an agreement with that government setting forth the amount of the local currencies to be generated, the terms and conditions under which they are to be used, and the responsibilities of A.I.D. and that government to monitor and account for deposits and disbursements?

c. **U.S. Government use of local currencies:** Will all such local currencies also be used in accordance with FAA Section 609, which requires such local currencies to be made available to the U.S. government as the U.S. determines necessary for the requirements of the U.S. Government, and which requires the remainder to be used for programs agreed to by the U.S. Government to carry out the purposes for which new funds authorized by the FAA would themselves be available?

d. **Congressional notice:** Has Congress received prior notification providing in detail how the funds will be used, including the U.S. interests that will be served by the assistance, and, as appropriate, the economic policy reforms that will be promoted by the cash transfer assistance?

DRAFTER:GC/LP:EHonnold:5/17/91:2169J

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NEW DELHI, INDIA

## UNITED STATES AGENCY for INTERNATIONAL DEVELOPMENT

April 29, 1992

ACTION MEMORANDUM FOR THE ASIA ENVIRONMENTAL OFFICER

Through: Steven P. Mintz - Acting Director, USAID/India

From: John Grayzel<sup>DES</sup> - USAID/New Delhi Environmental Officer

Action: To approve a Categorical Exclusion from Environmental Procedures for USAID/India's AIDS Prevention and Control Project (386-0525).

Background: The AIDS Prevention and Control Project is designed to assist the Government of India to reduce the spread of the Human Immunodeficiency Virus infection. The project will support non-governmental organizations to extend the reach of the Government of India National AIDS Control Program in the areas of condom promotion, behavior change, and the control and treatment of sexually transmitted diseases. The project will work in the State of Tamil Nadu and will coordinate closely with the state level program.

Section 22 of the CFR, Part 216.2(G) (2) (vii) identifies projects involving nutrition, health care or population and family planning services as ones which are categorically excluded from an environmental examination, assessment or impact statement, except to the extent that any activity (for example, construction of facilities, water supply systems, waste water treatment, etc.) may directly affect the environment. The project will fund no activities that have a direct effect on the environment and is, therefore, eligible for a Categorical Exclusion.

Recommendation: That you sign below indicating your approval of a Categorical Exclusion for the project.

Approved/Disapproved

M. KUK, Asia/D - 5-28-92  
ASIA Environmental Officer

Clearance: PDPS/PDI: JTarter

## TECHNICAL ANALYSIS

Since the first description of AIDS appeared in the medical literature in 1981, the epidemic has become a global health crisis. During the last eleven years, the general philosophy toward control has been to employ a wide spectrum of approaches to prevent transmission of HIV and reduce mortality and morbidity associated with HIV infection. These interventions have included:

- o developing epidemiologic surveillance capability to monitor and project trends in the epidemic
- o policy dialogue with decision makers to ensure commitment and support for control/prevention activities
- o performing research on sexual and other risk behaviors
- o increasing the safety of blood transfusions
- o HIV/AIDS awareness campaigns aimed at the general public
- o targeted IEC activities for populations engaged in high risk behavior
- o improving the management of other sexually transmitted diseases
- o promoting and improving the access to condoms
- o improving the diagnosis and care of persons with HIV related diseases
- o improving access and content of counseling of HIV-positive individuals
- o providing psychosocial support for survivors of AIDS victims
- o establishing care for orphans of AIDS victims
- o research on curative therapies and preventive vaccines etc.

Since 1987, USAID has played a major role in supporting many of the above activities. Specific projects have included: production of videos directed at workers; planning and implementing HIV/AIDS information curricula in schools; special programs directed at truckers; social marketing of condoms; provision of free condoms; establishing anonymous HIV testing and counseling centers; setting up AIDS information telephone hotlines; etc.

An inherent weakness, early in the fight against AIDS, was a lack of systems for monitoring and evaluating the efficacy of these varied interventions. Until very recently, the international health community was unable to determine what worked and what didn't. In 1991, a major review of USAID AIDS control activities was performed. During that review, seven major lessons became apparent:

- (1) We can prevent HIV infection on a limited basis;
- (2) Increasing demand for and access to condoms has been a key part of success to date;
- (3) Treatment and diagnosis of STDs play a major role in prevention and control of HIV infection;
- (4) We have had the greatest success with NGOs and PVOs which have been able to mobilize rapidly and respond to the current crisis;
- (5) We have not had an impact on HIV infection at the national level, in part, because of lack of concentration of resources;
- (6) We need to learn more about communications for behavioral change and about sexual behavior in order to refine prevention and control strategies;
- (7) We have learned about the critical importance of multiple reinforcing channels of communication aimed at changing knowledge and attitudes of individuals and societies toward sexual behavior, as a prelude to behavior change.

Applying lessons 1, 2, and 3 above, the APAC project will focus on three key interventions, which have been shown to be the most important and effective in preventing and controlling AIDS:

### **Intervention 1 - Increase demand and access to condoms**

Condoms are the only physical barrier available that can stop the sexual transmission of the virus from one person to another. Increasing evidence from the U.S., Europe, and Africa shows that condom use protects against HIV infection. The more consistently condoms are used, the more protection they provide.

Programs for promotion and distribution of condoms to those who practice high risk sexual behavior have been very successful. In Africa, condom shipments by A.I.D. in response to demand have increased five-fold, from 33 million in 1987 to 174 million in 1990.

### **Intervention 2 - Promote behavior change to reduce sexual partners and high risk sexual behavior**

Research shows that 75% to 80% of all HIV transmission is through sexual intercourse. This significantly increases with an increased number of sexual partners, due simply to the greater probability of having sexual intercourse with an infected person.

Populations that regularly engage in high risk sexual activity (multiple partners, frequent use of commercial sex workers, etc.) have been shown to be amplifiers early in the AIDS epidemic and are thus termed "core transmitters." "Core transmitters" is an epidemiologic concept designating a relatively small group of individuals who are directly or indirectly the source of a disproportionately high number of infections. According to recent modeling exercises, when a case of HIV infection is prevented in the core group, the total health impact is three to six times greater than preventing a case in the non-core group.

### **Intervention 3 - Improve STD services**

Patients with STDs are, by definition, engaging in high risk behavior. They constitute a logical target for specific HIV/AIDS IEC campaigns. They have the additional advantage of being accessible and are often more open to behavior modification, due to the presence of uncomfortable symptoms.

The chances of becoming infected with HIV through sexual intercourse with an infected person are between 1/100 to 1/1000 from male to female and 1/4 to 1/10 of that from female to male contact. STDs that lead to genital sores, such as syphilis, chancroid and herpes, provide physical portals of entry and exit for the AIDS virus. The presence of an STD multiplies the efficiency of transmission of HIV from 5 to 20 times. Effective

treatment regimens for all of the common STDs, except herpes, are now available, using either syndrome management protocols or laboratory based diagnoses.

The combined positive impact of targeting STD patients with special HIV/AIDS prevention messages and decreasing the prevalence of STDs and thus their multiplying effect on HIV transmission, make the improvement of STD services a powerful weapon in controlling the AIDS epidemic.

**Applying Lesson 4 - Success with NGOs:** Activities will be implemented mainly by non-governmental organizations.

**Applying Lesson 5 - Concentrate resources:** There will be a focus of resources on high risk groups in the State of Tamil Nadu. This will avoid spreading resources too thinly and help ensure a positive and documented impact on HIV prevalence.

**Applying Lesson 6 - Need for research:** There will be a major emphasis on research to study knowledge, attitudes and behaviors of target populations. Information from this research will be synthesized continually and fed back into the project to improve effectiveness of communications efforts.

**Applying Lesson 7 - Importance of multiple reinforcing communication channels:** There will be a variety of communications approaches including mass media, folk media, interpersonal communication and counseling to bring about behavior change.

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## ECONOMIC ANALYSIS

The consequences of the AIDS epidemic on the demographics, health delivery system and economic productivity of the country can only be estimated.

AIDS will affect mortality, possibly fertility, the rate of population growth and the age structure. Mortality can be estimated if HIV seroprevalence is known, however, the future level of HIV is difficult to predict. Therefore, mortality rates cannot be estimated with accuracy over the long term. Fertility rates are also difficult to estimate since it is impossible to determine how people will react to AIDS in their family size decisions.

Decreased productivity during sickness and the premature death of productive individuals will have an effect on the economy as a whole. With AIDS, the loss can be expected to affect people of all income levels unlike other preventable or curable diseases which mainly affect the poor. Additionally, when adults die, family and community incomes are strained by the financial requirements of dependents, comprised of surviving partners, orphans and the elderly.

Since AIDS affects adults in their prime productive years, labor shortages may be experienced in regions of the country and in some of the highly skilled job categories in urban areas. Losses will also be felt due to decreased productivity. If the epidemic spreads into rural areas, food security may also be affected.

In countries in which there is already a significant AIDS epidemic, the cost of AIDS prevention and control activities, and particularly the care of AIDS patients, represents a significant proportion of government health expenditures. Staff and facilities are being swamped with AIDS related tasks.

In India, the average cost per day for inpatient care of an AIDS patient is estimated at 500 rupees (estimated at CMC, Vellore where HIV positive and AIDS patients are being treated). Most AIDS patients will have multiple hospital admissions until death, requiring an average of approximately 6 weeks of hospital care. This would generate an average cost per patient of 22,000 rupees (\$750), not including many of the expensive life extending measures used in other countries. Medical treatment of AIDS patients only provides symptomatic relief and some extension of life. It does not cure the patient and, thus, mortality is not affected.

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The total amount of funding programmed for the APAC project is \$10 million over seven years. If this amount were to be used solely for patient care, approximately 13,500 persons would benefit. Alternatively, the allocation of these resources is expected, through the strategies of targeted education, condompromotion and improving the quality of STD services, to benefit approximately 3,000,000 persons in the State of Tamil Nadu, at a cost of \$3.33 per person.

The decision to initiate a project of this nature clearly cannot be based on an economic analysis of a specific set of interventions. However, it is important to consider whether the selected interventions represent the least-cost methodologies, given the currently available and socially acceptable technical approaches. The project will incorporate the most advanced methods and strategies that have already been shown to be effective, in India and worldwide. Results of ongoing programs and studies (both in India and elsewhere) will be monitored by project staff throughout the period of project implementation. As new project activities are planned, the project will incorporate materials and methodologies that have proven most effective. This flexibility, built into the project design, will assure that the cost effectiveness of project interventions are maximized.

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SECTION II

PRIORITIES FOR INTERVENTION: OTHER LINKAGES WITH THE SOCIO  
-CULTURAL ETHOS

1. INTRODUCTION

It is evident from Section I that the socio-cultural ethos for AIDS prevention is a complex one and merits careful consideration prior to intervention. The following may be expected to pose major barriers and will need to be addressed in terms of priorities for action:

- . The general limitations of the public health sector and the multiplicity of health problems that need to be addressed.
- . The paucity of research - indepth, regionally focussed, as well as segment-wise - on sexual behavior, beliefs and attitudes towards sexuality and sexual behavior with a gender orientation within and outside socially accepted domains, other health-related beliefs and behavior pertinent to risk-enhancement, eg. skin-piercing, blood/organ receipt, maternity and termination of the same, STDs in particular.
- . The tenuous relationship between different sectors that will play a key role in AIDS prevention, viz. NGOs, the private health sectors, the prevailing sub-cultures of homosexuality, eunuchs, sex work, etc.
- . The limited emphasis merely on surveillance, blood-related services and legal measure to control the epidemic on the part of the government.
- . The low acceptability and poor quality of condoms and the limited market-strategies for condom promotion.
- . The low status of women in Indian society and the dominance of patriarchy that disempowers women, and encourages, implicitly and explicitly multiplicity of partners among men and the absence of preventive behavior.

- . The apathy of key agencies towards the epidemic, viz. the mass media, the NGOs and the religious and social agencies.
- . The lack of a vigorous public debate on ethical issues related to HIV/AIDS.
- . The total lack of attention to developing services that will be needed for the sick and dying.
- . The exclusive focus on certain regions in AIDS preventive activities, viz. Maharashtra, Tamil Nadu, N>E> States and major cities like Delhi and Calcutta and on certain groups like sex workers, commercial blood donors, homosexuals, medical and para-medical workers within the health system and other groups identified globally as high risk behavior groups to the exclusion of those that are culture-specific, eg. eunuchs, devadasis, traditional healers, etc. and those segments about whose behavior, little is known, eg. out-of-school youth, migrant labour, the unorganized sector workers, adolescent and adult women, etc. The above represent only the major barriers in the current socio-cultural ethos (others are identified through-out Section I).

## 2. PRIORITY AREAS FOR USAID: SOME CONSIDERATIONS

It is suggested that USAID could focus broadly on the following to address these shortcomings and problems, either directly or through the proposals it funds. It may be asserted that strengthening the current health infrastructure and services that may be harnessed towards AIDS prevention as well as enhancing person-power skills should be the major thrust of this assistance.

- i) - Sensitisation and training for different sections:
  - (a) Medical and para-medical workers (including all levels, particularly the lowest) in the public and private sector and in the allopathic and alternate systems of medicine as well as traditional healers;
  - (b) Representatives of NGOs working directly in health - either PHC or with specific health problems, with groups that are identified as being vulnerable, especially the culture-specific ones, mentioned earlier and those that are difficult to access, eg. local STD 'doctors' in red-light areas, rural areas, etc. Smaller NGOs will need special attention;

- (c) Community healers, who have an influence on people and can mould public opinion and attitudes. This group needs to include eminent personalities, who are 'high profile', as well as local leaders. In the former category, TV and film stars and sports personalities would be key persons, as they are known to have high visibility and appeal. Youth and women leaders should be given priority as peer influence is likely to be promoted. Leaders of other groups that are likely to have favourable attitudes towards health promotion may be included, eg. parents, educators, religious organisations, public service groups, etc.;
- (d) Mass media representatives on information, message preparation, pretesting, ethical issues, etc. Other than the established formal media, exponents of traditional media need specific training, viz. puppet theatre, dance and music;
- (e) Researchers in the field of health and allied fields on rapid assessment procedures, K.A.P. research and especially on qualitative research methods;
- (f) Workers in the area of sex education, family planning, abortion, counselling, social work, etc.

- If agencies submit proposals for undertaking such training and sensitisation, it is important that they be agencies known to have expertise in the channels used for training and the training methodology, and be provided adequate technical assistance on HIV/AIDS and the issues involved, and exposure to similar activities in other parts of the world. Training of trainers workshops are advised.

The government would be in a position to conduct workshops for its own staff, with assistance from established institutions like AIIMS, major hospitals whose key staff have already received training, colleges of social work, etc. However, the task of training and sensitising other groups could be divided as follows:

ANNEX I

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GROUP	AGENCY	GROUP	AGENCY
Private sector of Health (Allopathic)	Indian Medical Association, Government Hospitals.		
Alternate systems of Medicine	Key Staff of Relevant Institutes	Traditional Healers	Local NGOs
NGOs	Government Hospitals/ Colleges of Social Work	Smaller NGOs	NGOs well-established in the region
High Profile Community Leaders Approach: More Inter-personal	Key Staff of Educational Institutes/Government Hospitals/Mass Media	Youth Women Parents Educators Religious Organisations, Public Service Groups	Local NGOs/Colleges of Social Work
Established High Risk Behaviour Groups/Those Difficult to Access Approach: More Inter-personal	NGOs/Groups currently working with these sections, preferably with peer educators	Mass Media Representatives - Public Media	Mass Media Training Institutes Governmetn Hospitals, Edicational Institutes, Advertising Agencies.
Specialised Wrokers, eg. sex educators, family planning	Government Hospitals/Colleges of Social Work	Smaller Media Approach: More Inter-personal	Mass Medial experts and local NGOs familiar with these groups
Researchers	Institutes of Social Sciences and Social Research with expertise and Market Research/Operations Research Agencies.		

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ii) Strengthening STD-related facilities:

The government facilities remain the major facilities for STD treatment. Posts within these are often the least sought-after by medical and para-medical workers in view of the stigma and the limited facilities. It is essential to work on the image of the STD Clinics and refurbish the knowledge and skills and motivation of their personnel. It has been suggested that STD facilities be integrated with other services and not be provided, exclusively. This needs to be looked at, closely, and models provided to the government for assessment and consideration. Offering outreach services with sex-education and counselling facilities is one suggestion made by us to revamp their current image.

The network of private STD facilities in India needs to be studied, closely. Formative research on STD needs to be carried out in different regions, as was conducted by UNICEF.

The preparation of audio-visual material on STD, HIV and outlining the specific role which can be played by STD workers in prevention is needed.

Development of workers for inter-personal communication, who can carry this information to the practitioners has already been suggested.

The above may suggest, however, that new facilities will not need to be created and that strengthening the current facilities is adequate. Research indicates acute shortage of current facilities. In view of the urgency and limitation of funds, however, it is primarily essential to strengthen the available facilities, before looking into newer possibilities.

NGOs that offer to integrate STD services with its current programmes may be given priority for funding, as their current services are likely to be acceptable to the people and integration may facilitate the reaching of these services to different sections of the population, hitherto unreached by STD services.

iii) Improving the standard, adequacy, awareness and utilisation of testing facilities for HIV:

It is known that current testing facilities for HIV are mainly restricted to metropolitan centers and major hospitals in India. Launching of campaigns on HIV that develop risk-assessment skills and promote voluntary testing will be followed by a need for facilities that are accessible to the people. Government facilities in this area need strengthening from the angle of adequacy, spread and quality. The private health sector may,

however, be approached to a greater extent by the people, in view of the overall utilisation pattern (discussed in Section I). It will be necessary to monitor closely the testing facilities of agencies that offer them, to ensure voluntary, anonymous testing and confidentiality of results. In this context, it is suggested that blood donors be encouraged and counselled about HIV testing, as currently, they are not informed about the results. Associations that work on blood donation and the government health sector will need to have a dialogue to work out the logistics of such an arrangement.

It is equally important that all staff involved in testing be trained not merely in the technical aspects but the psycho-social aspects of HIV/AIDS. The possibility of encouragement to private manufacturing units for indigenous kit development and rapid tests needs to be looked into in view of the cost and time involved currently in HIV testing.

It is possible that this is not a priority of the government or NGOs, vis-aviz AIDS prevention. However, the 'blitzkrieg' of HIV/AIDS related information is likely to create panic, even if all precautions are taken to avert it, and testing will be the first service demanded by the people. No testing facility should be permitted to function without counselling and referral services, that will need to be built into the programme.

- iv) Promoting condom use and ensuring an adequate supply of 'quality' condoms through a wide network of outlets:

It is essential to delink condom use from family planning or rather, widen the linkages of condom use with freedom from 'infection', 'hygiene', 'sex without tensions', 'sex without harm to self or partner'. The desirable qualities of the condom need to be researched into as opposed to the focus hitherto on the negative features. There is need to launch the 'condom' as a fresh product, delinked with the 'nirodh' perhaps having its own Indian name or an adaptation to the current name. This assignment will need to be handed to an experienced market research agency linked to an advertising agency that can promote the condom, with its new 'image'. However, while presenting this new image, care needs to be taken that values related to sex are not challenged such that the condom is promoted as a licence to sexual behavior, irrespective of its context. It is equally important that while condom use may be criticized, it does not denigrate the status of women, as some current advertising campaigns have done. There is adequate expertise in India on condom promotion as it has been part of the family planning programme, for years. The FPAI and other organisations that have experience with condoms use and with sex counselling, will need to be

involved in this effort, as also agencies like PSI involved in social marketing of condoms. Reluctance on the part of family planning workers may be expected, but it is important to harness their expertise and involve them in the process.

The 'enter-educate' approach to condom promotion needs to be explored further and the involvement of institutions exploring mass media innovations, eg. Institute of Social Design, Institute of Mass Communication and traditional media like N.C.P.A. (Bombay) and other cultural centers can be encouraged through research grants.

Condom promotion will need to be backed by availability of cheap and good quality condoms. Widening the condom production market is a strategy that is currently being tried. However, the pricing and marketing strategy of these condoms still places them as being targeted towards upper middle class, educated men and does not view the rural and socio-economically underprivileged groups as a priority. With government subsidy and other incentives in terms of land, loans etc., it is possible to get others interested in the manufacture of condoms to widen the types of condoms available. It is equally imperative to assist agencies that will explore innovative outlets for condom distribution that go beyond the conventional ones, and work on an incentive scheme for these outlets to provide condoms.

In Section I, it was noted that proper use of condoms, disposal of condoms and counselling about condom use are areas that are neglected. It is essential to find agencies willing to explore these areas. Competitions may be encouraged on these themes through the print media for eliciting suggestions from the general public, eg. disposable packets with condoms. Research on this aspect also needs to be carried out both, to know current practices, and possibilities and to test new ways of getting the message across and practices that are feasible. While printed matter may be useful, illiteracy must be a factor to be considered. The approach should thus be multi-pronged.

The provision of condoms by the USAID needs to be reconsidered, as they are identified as 'government condoms' that have a poor image. It is questionable if proper conditions of storage and quick distribution are realistic expectations from the government. Instead, encouraging and subsidising local production, with international collaboration and assistance with marketing and technical know-how would be a more realistic proposition. In addition, condoms need to be provided directly to NGOs who are willing to organise distribution especially among groups identified as being at risk. Accountability will, however, need to be looked into,

carefully. It is suggested that distribution of condoms should not be without cost; even if subsidised, there should be a small price on condoms, as it is established that 'free' condoms are not seen as trust-worthy.

v) Initiation of Research:

It appears that in India, research in HIV is mainly restricted to the bio-medical sphere. While such research is rudimentary and needs encouragement, it is more important at this juncture in the epidemic, to conduct research on cultural beliefs and practices that pre-dispose risk behavior and transmission of infection. KABP studies are being conducted in different parts of the country but no indepth, qualitative research has yet been attempted, on areas identified in Section I, eg. non-penetrative sexual activity, women's sexual practices, blood-related and sexual practices of eunuchs, etc. Priority needs to be given to research that will be directed to intervention and action-research should be given priority.

vi) Initiating Preventive Education and Supportive Services through NGOs:

Throughout Section I, the overpowering need for NGO to get involved via preventive education services, providing awareness and skills, and support and counselling has been discussed. It is important to provide exposure to select NGOs on such services as they have been provided in other parts of the world and technical expertise to integrate AIDS education and services, within the gamut of their services. Key NGOs may be identified initially, that are keen to take up this work, with careful attention to their motives, past experience, infrastructure and capacities. These, in turn, can be motivated to act as trainers and mobilisers of other NGOs in the region, that are lacking in some aspects of the above, but harbour potential. It is specifically necessary to ensure that only those NGOs currently targeting high risk behavior group are not targeted, as this will implicitly build stereotypes about those who are at risk. All NGOs need not work on all aspects of HIV prevention and support, but be trained for working on those aspects, with which they are comfortable and have some basic expertise. Sensitisation to all aspects is, however, essential.

Special effort will need to be made to initiate agencies to take up supportive services for the sick and the dying and their loved ones. Currently, there are NGOs that exclusively address this need. In order to integrate AIDS affected persons, it may be appropriate to work initially with these agencies. However, since the current facilities are limited and do not address the need of

certain marginalised groups, special effort will need to be made to encourage other NGOs to take up this responsibility.

It is expected that after the initial hesitation, several NGOs will come forth to take up these challenges. While all efforts need to be encouraged, careful attention needs to be given to the content and methodology of their services, to ensure sensitivity to the ethical and humanitarian aspects of the problem.

3. PROPOSED CRITERIA FOR FUNDING PROPOSALS

The guidelines for proposals to be invited must be kept simple and clear, as most NGOs tend to be daunted by complex demands in proposal-preparation. The following areas will need to be considered in the proposal.

a) Content: In the area of prevention, programmes that heighten awareness about HIV as well as provide specific preventive education and skill-development need to be encouraged, as there is a possibility of NGOs wanting to take up the former without the latter. Supportive services that provide either or all of the following components need to be a priority.

- . Counselling including hotline
- . referral
- . housing assistance
- . financial and legal aid
- . hospices and clinical management of the sick and dying
- . advocacy and community mobilization

NGO-government collaboration is possible in several areas, eg. preventive education, STD clinical services, condom promotion and distribution. NGOs, however, could be encouraged to take the lead in supportive services for the ill and dying rather than clinical services, in which the government is likely to take the lead. However, there may be some NGOs that offer clinical services, that may offer to integrate services for AIDS-affected persons as well as other NGOs which may wish to offer such services. These will need to be examined thoroughly to ensure absence of duplication, motivation and the financial aspects of the programme.

NGOs that take up the task of training and gearing the private sector of health including those in alternate systems of medicine could be encouraged, as they are likely to be more successful in this task than the government.

It is important to encourage the following in proposed programmes:

- i) NGO-government inter-dependency in areas identified earlier, eg. government-produced material can be distributed by NGOs or vice versa, the government can refer persons to NGOs for counselling and supportive services, NGOs can initiate government health officials on the advisory committees of its programmes, condoms can be provided by the government to NGOs for distribution, etc. This inter-dependency already exists in India in the field of social welfare, education and health and needs to be further strengthened in addressing HIV/AIDS.
- ii) NGO networking to foster sharing of resources and avoidance of duplication. It is well established that the availability of funds and the opportunity to pioneer may lead to a spirit of competition and empire-building. NGOs in India, however, do have a history of networking. Ways in which the spirit of co-operation can be built into the project need to be considered, seriously.

Different NGOs can be encouraged to present proposals for funding projects in collaboration, carrying forth different components of the proposed project. These components can be planned vis-a-vis NGO expertise and capacities. Such proposals can be given priority in funding.

Some NGOs can be granted funds to stimulate net-working. An example of such an NGO is the South India AIDS Action Programme. These will have to be new NGOs as existing NGOs may be unacceptable for such work to other NGOs.

NGOs can be dissuaded from attempting to provide a wide variety of services, using other NGOs for referral for services that they need not provide. Ofcourse, NGOs will need to be regularly informed of services available with other NGOs, as often there is a tendency to serve in isolation. NGO competition can be kept a minimum by providing smaller amounts to few NGOs, as this may discourage jealousy and rivalry. Smaller NGOs need special attention for funding and can be encouraged to tie up with other small NGOs to strengthen their infra-structure, as mentioned earlier. It is essential that quasi-government agencies and large NGOs be considered separately for funding. Such agencies are likely to attract

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funding due to their reputation, experience, and proficiency in proposal-writing and planning programmes and may have a head-start vis-a-vis smaller NGOs. Smaller NGOs, in turn, may wish to submit proposals piggy-backing on larger NGOs, that have these qualities. This can be encouraged provided the autonomy, group-specific targeting and other advantages of the smaller NGO are not lost as a result of this piggy-backing.

- b) **Methodology:** It is important to ensure that due consideration is given by the project to the methodology of the project and pre-testing occurs. Community participation needs to be integral to this effort in order to facilitate empowerment of the target-groups and effectiveness of the programme. Self-support groups will need particular encouragement. A time-schedule will need to be worked out from different phases of the programme. Emphasis needs to be given to programmes that emphasize integration with other services. Demands for augmenting the infrastructure may have to be met as NGOs are often lacking in this aspect. Training of current staff and adequate remunerative incentives will need to be worked out to heighten employee motivation. Testing of innovative methodologies, with adequate sensitivity to ethical aspects will need encouragement. Ongoing evaluation will need to be worked into the programme, for which specific criteria will have to be worked out. Training in evaluation methodology is a must for most NGOs who do not evaluate outcomes, even if process is evaluated, as a routine. Formative and baseline research prior to planning of intervention also needs to be carried out to ensure that programmes match the needs and realities of the given context and achieve stated outcomes. The outline of this research and the findings and the subsequent intervention and the measurement of outcomes must be presented to the funding agency.

Targeting is an area that needs special attention. It may be more effective for NGOs to be limited and specific in targeting geographically and group wise preferably within the context of groups with which the NGO already has a rapport. This does not rule out targeting newer groups. The justification of this targeting will need to be spelled out and assessed carefully. Groups targeting

those beyond generally identified high risk behavior groups, must be funded in equal proportion to those that target high risk behavior groups, so as to carefully balance the NGO efforts. It is particularly essential to target groups that are particularly vulnerable, eg. women from marginalised sections.

The process of ensuring the involvement and participation of leaders and beneficiaries needs to be spelled out carefully, as it has a direct impact on the outcome of the programme. Programmes that target incarcerated populations and those that are dependent on the NGO for subsistence or meeting other needs, must be considered more carefully as the target population may not be in a relationship to the NGO which is favourable to participation and empowerment.

Careful outlining is essential of the expected outcomes that may be spelled out in quantifiable and qualitative ways. Proposals also need to show sensitivity to the possible negative side-effects of the programme, the strategies to reduce these, the limitations of the programme and be clear about what the programme does not claim to achieve. Programmes that are over-ambitious or vague as to outcomes and insensitive to limitations are not likely to be effective or efficient.

c) Consideration to Ethical Aspects

Proposals will need to give careful consideration to ethical concerns in programme implementation. Some of the questions that will need to be addressed are as follows:

- What extent of autonomy will the programme generate among the beneficiaries?
- What procedures will be adopted to ensure confidentiality and anonymity?
- What steps will be taken to prevent stigmatisation?
- How will self-reliance be encouraged through the programmes?
- To what extent will the beneficiaries be involved at all stages of the programme?
- How will the programme take a holistic perspective on the problem?
- How will the programme be integrated with existing programmes?

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- What modalities will be adopted to make the programme sustainable and if possible eventually handed over to the community?

4. Overall Priorities

It is important to find programmes in parts of the country that have not been covered by AIDS prevention activities so far. Though a focus has been maintained on Maharashtra and Tamil Nadu, it is important to target other regions, eg. States that have been established as backward in India in the Northern belt and the North Eastern States (not merely concentrating on the problem of I.V. drug use).

It is essential to prioritise action-oriented work but a research component needs to be built into the work, as without adequate needs assessment and appreciation of the specific cultural and behavioral context, intervention is not likely to be effective nor sustainable. Priorities for action will emerge, strategies can be pre-tested and process and product outcomes evaluated only through sensitive research.

This does not imply that research-oriented work should be neglected. As identified earlier, there is urgent need for considerable research on behavioral issues related to AIDS. Social and behavioral scientists need to be encouraged to carry out such research, with adequate consideration to the ethics of using human subjects. Research Institutes need to be invited to work on relevant research. Ideally, researchers and interventionists need to join hands to make AIDS intervention successful. Findings of AIDS-related research should be made more accessible to programme planners. Simultaneously, interventionists can identify areas of further research and test out proposed strategies. This feeding of action and research into one another can help to ensure a realistic, effective AIDS prevention and management programme and meet the urgency of the situation.

**ADMINISTRATIVE ANALYSIS**

1. Assessment of NGOs in Tamil Nadu
2. Assessment of Schools of Social Work
3. Administrative Assessment of Voluntary Organizations
4. Financial Capability Assessment of Voluntary Organizations
5. Sample Format - Grant Agreement to an NGO
6. Adequacy of Accounting and Reporting System

## ASSESSMENT OF NGOs IN TAMIL NADU

The APAC project will work primarily through Non-Governmental organizations (NGOs). The NGO organizations have the advantage of being able to carry out innovative programs because of their voluntarism. They work at the grass-root level and so are able to carry out community based program more efficiently and are not normally constrained by bureaucratic rules and regulations.

In Tamil Nadu there are a large number of NGOs both in the cities and the rural areas. In Madras city alone there are over 263 NGOs of which over 100 are working with target audiences which are appropriate for APAC activities. By working through these organizations, the APAC project will be able to reach a large number of people. The project has identified certain priority groups such as commercial sex workers, sexually active men with multiple partners, other sexually active women, adolescent and school drop-outs. The NGOs have a better access to these groups compared to the Government systems. While it is advantageous to work with the NGOs they have their limitations. Many of them are small organizations and their present activities are not related to AIDS and so they do not have the technical capability to implement APAC activities without technical assistance.

The following review of NGOs in Tamil Nadu classified organizations in a manner relevant to the needs of the APAC project. The categories are as follows: NGOs working at the grass-root level, those organizing special clinics like MCH, those working for special groups such as street children, destitute women, truck drivers; those doing counselling; those organizing training programs and those doing research.

### 1 Community based NGOs

#### 1.1 Animators

As part of the adult and non-formal education programs, animators are selected from the community who are responsible for educating illiterate adults or youth. Because the animators live in the community they serve, they know the community well and are also available all the time. The animators are aware of those in the community with high risk behavior and can reach out to them with the education program for behavior change and condom utilization. People can approach them at any time for their personal needs including purchase of condoms. Many of the NGOs visited are working with animators eg. ICCW, Guild of Service - Planned International, YWCA, Asha Nivas, CHAD-CMC, Khajamalai Ladies Association and MCCSS. The animators can be asked to sell the condoms and the commission provided by the manufacturers will be a financial incentive for them.

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## 1.2 Mahila Mandal and Youth Clubs

Many NGOs work with organized community groups such as Womens Clubs and Youth Clubs. These groups play an important part in development and welfare programs. They are an influential section of the community and can be used for educating the rest of the community. Community participation is also best ensured by working with these groups. These clubs conduct education programs through street plays, Villupattu and Kathakalashepam. Very often these are used for creating a social awareness in the community. It has also been used by many NGOs for health education. Of the NGOs visited MCCSS, Asha Niwas SOC SEAD, CHAD, mentioned that they used these groups. If the technical information is given to the Youth Club, they can be asked to prepare the script or song. This process will be of special educational value to those involved in presenting the education program - which will be the members of the Youth or Women clubs.

## 1.3 Health Volunteers and Community Health Workers (CHW)

The Health Volunteers, and Community Health Workers (CHW) like the animators, are grass root workers who belong to the community they serve and very often selected by the community. They are older members of the community compared to the animators and so are held with greater respect. The community normally approaches them for common health problems. The community health workers are called "change agents" because of their responsibility to educate the community and change their practices. They can also be used for referring individuals with symptoms of STD to the nearest clinic. One of the responsibilities of the CHW is to identify pregnant women and refer them to the MCH Clinic. Those who require abortion also approach the CHW. Because of these roles of the CHW, they are useful persons not only for education for behavior change but also for directing the vulnerable population to the appropriate clinics.

The CHWs are familiar with the use of various health education materials and so will not need further training in this area. CHW are used by most NGOs involved in primary health care. These are FPAI, CHAD-CMC, VHS, CSI Council for Healing Ministry, Grace Kennett Foundation, IPP-V.

## 1.4 MCH Clinic

Most NGOs, involved in Primary Health Care conduct MCH clinics usually in the community. The health team visit the community periodically for conducting the clinic. The scope of these clinics could be enlarged to include education, counselling, condom distribution, not for F.P. alone but also for AIDS/STD prevention.

There are several NGOs conducting MCH clinic either as part of the Govt program like the IPP-V, Mini PHC, or on their own (same organizations as above). The other members of the MCH team such as multipurpose health workers, village health workers, and doctors also have a role to play in the IEC. At present most of these health workers are ignorant about AIDS and have wrong concepts regarding its cause and prevention. It will be necessary to organize education programs for them before they are involved in educating the rest of the community. Since they are responsible for giving intramuscular injections either of antibiotics or vaccine in the community they need to be given special training in the sterilization technique. At present CMC is educating the PHC staff of the whole of N. Arcot district in a phased manner. Other NGOs, could take on similar responsibilities in the cities and the rural areas.

2.1. Port Trust Workers, Railway and Road Transport Workers and Factory Workers

Workers of the above mentioned organizations have been identified as a high risk group and efforts have already been to reach out to these groups to organize educational programs. The industrialists as well as the union leaders contacted were of the opinion that educational program for workers is vital. The Madras Management Association has already organized programs for workers of a few industries with the help of consultants(DESH). This program needs to be expanded to all industries in major cities. The Government has a Central Board for Workers Education. The worker-teacher who is a key person in this program can be educated regarding AIDS/STD and they can be made responsible for educating the others. Organizations such as SIMA and the Chambers of Commerce could be incorporated into this program. Certain NGOs may choose industrial workers as the target population or the industrialists can make use of consultants in their area for providing the education. It will be essential not only to educate the workers but also the housewives.

Some of the industries visited such as the Madras Rubber Factory (MRF) have education programs for both the factory workers as well as their spouses. The attendance at these meetings depend on the topic and so it will be necessary to make the program as attractive as possible. MRF indicated that AIDS can be one of the topics.

## 2.2 Police and Army Personnel

Another risk group identified were the policemen and army personnel. One of the Commissioners of Police indicated that it is possible to organize special programs for the policemen periodically. Similar to the program planned for industrial workers, the wives of policemen will also have to be educated. (None of the NGOs have worked with the police force as yet). Apart from programs organized for the police force the police trainees should also be provided education on AIDS and STD as they will be the policemen of the future.

## 2.3 Truck Drivers:

Recent studies have shown that 11 % of those attending STD clinics are truck drivers and so form a very high risk group. Further, by the nature of their work of traveling widely within and outside the State, they can spread the disease from one place to another especially along truck routes. High priority needs to be given to this group. Work has already been done by AIDS Research Foundation of India and SIAAP to educate and distribute condoms to the truck drivers at the rest stops on the truck route. Many more NGO's will need to use this strategy in various parts of the State. Different approaches could be tried to reach the truck drivers. This may be a topic for operation research study.

## 3. Education of Special groups

### 3.1 School dropouts and Street Children

This is very vulnerable group and is known to have unsocial behavior such as gambling, alcohol and drug abuse, petty thefts and deviant sexual behavior.

Certain organizations such as Asha Nivas, Anbu Illam, of Salem and Coimbatore, Namban of Madurai, ICCW have special programs to help street children. They have a shelter home and also provide them with vocational training and if possible find jobs for them. These organizations are willing to provide education on prevention of AIDS/STD as well as substance abuse which is common among these children.

### 3.2 Destitute Homes

Destitute Homes and vocational training centers are organized by several NGOs for the girls who are predominately from slums. They are given vocational training, non-formal education. This is a high risk group and these institutions are ideal for giving education on AIDS and STD prevention. Some of these girls have already been involved as sex workers. ICCW, YWCA, Asha Niwas, MCCSS, SOC SEAD, Kajamalai Ladies Association which are already involved in these activities have expressed an interest in doing AIDS prevention education also.

### 3.3 Schools and Colleges

Teenagers are a vulnerable group. School and college students are known to experiment with sex, partly out of curiosity and more so out of ignorance. They lack scientific information. They do not receive it in their home or schools and so they get it from peer groups or unscientific books. To overcome this lacuna and considering that college students do visit prostitutes, education in schools and colleges will have to be given high priority. A few NGOs have taken the initiative in organizing these programs. Initially there was doubt and apprehension in the minds of the Principals and teachers. The experience of Madras Medical College AIDS Cell, AIDS Research Foundation of India (ARFI) and CMC Vellore has been very encouraging. These institutions have received requests from other institutions to organize similar programs. It is also necessary to have counselling centers either in the college or in a place nearby where students can receive advice and help. Some institutions like Sacred Heart College have such a program but do not call it counselling as they feel that it may deter the students from visiting the centre.

### 3.4 Role of NSS

The National Service Scheme is being implemented in most educational institutions. It is funded by the Govt of India.

The WHO organized a training program for NSS Coordinators through the Madras School of Social Work and Avinashilingam Institute for Home Science, Coimbatore. The NSS can be effectively used for the IEC program.

To ensure this, the NSS students will have to be given education regarding AIDS, as well as how to communicate this information to the community. The NSS students can then take the responsibility of educating selected communities especially those living in slums in the neighborhood of their college. In view of the large number of college students available, the message can be spread to a large number of people. The Tamil Nadu MGR Medical University also has a NSS program. This could be a special task for the NSS in the medical colleges for the next few years. The University can instruct the NSS students in the college to organize camps especially because the medical colleges have slums around them.

#### 4. STD Treatment

It is estimated that only 10% of all STD patients take treatment from the govt. clinics. The rest take it from general practitioners or other institutions. To help improve the quality of service provided by the general practitioners they need to have continuing education.

- 4.1 The Lady Doctor Association has just begun this and has expressed its desire to do this on a larger scale. All general practitioners can be encouraged to attend this training program which include STD management issues and also counselling for those who are HIV positive (both pretest and post-test)

#### 4.2 Indian Medical Association

The IMA which has branches in all the towns and cities of the state can play an active role in the CME program. A panel of consultants may have to be selected for this. These consultants can be from the near by Medical college or specialists working in large hospitals or private clinics.

Except for the teaching hospitals all the hospitals of the NGOs provide treatment for STD patients along with the general outpatient clinic. No special effort is made to provide counselling. Even education of the patients is done to a limited extent. In view of this the General Practitioners will also need training in counselling and health education techniques. Since reporting of STD at present is very poor or negligible by General Practitioners an effort needs to be made to improve this.

- 4.3 Another approach to improve the quality of STD management is to provide a service which integrates STD curative service with preventive and promotive activities such as immunization, antenatal care, health education, family guidance or counselling, fertility clinics for those without children and family planning services - sterilization and abortion for those who wish to limit their family. Marie Stopes provides such integrated service in their clinics. They also encourage General Practitioners to refer patients to them.

Marie Stopes could be encouraged to franchise other private practitioners (groups) to provide similar services. This approach has the advantage that women who generally do not seek treatment, though affected with STD or its symptoms, will attend the clinic because of the holistic care especially if there are lady doctors to conduct these clinics. These clinics will have maximum impact if they are situated in the neighborhood in which sex workers are situated.

The MCH clinics organized by NGOs the IPP-V and Mini-PHC can have similar activities. Some of these organizations have indicated their interest in conducting such a program. As some of the NGOs do not have lady physicians the members of the Lady Doctors Association may be requested to participate in such a clinic.

- 4.4 Another approach will be to request the doctors of the medical college STD department to help conduct the clinic as done by MCCSS and the staff of MMC. The reporting system established in North Arcot district known as NADHI by CMC, which has been replicated in a few other districts can be used for STD also. NADHI is primarily for vaccine preventable diseases. The General Practitioners can be asked to report all suspected cases of STD on a weekly or monthly basis to a NGO in their district who has been identified for the purpose. The district data can be collated at state level monthly. This information can then be disseminated to all the practitioners and the government office monthly. This will help to monitor the occurrence of STD.

## 5. Special Activities

### 5.1 IEC

IEC is an important component of this project and is the strength of the NGOs. However they need education material and this has to be produced and as early as possible.

In the recent past, several institutes in Tamil Nadu have established IEC units in their organization. This includes the Tamil Nadu Integrated Nutrition Program (TINP), Danida project, IPP-V project and Family Welfare Dept. In the voluntary sector there are organizations such as Education Mass Media Association, Gandhigram Institute of Rural Health and Family Welfare and CMC Vellore.

The material prepared by all these organizations are widely used throughout Tamil Nadu and elsewhere. These centers have the capability of preparing education material by going through the process of pretesting and modifying the illustration as well as the message. CMC Vellore has a Audio Visual Unit which has been preparing flash cards, posters and flannelograph for over 25 years. TINP and DANIDA have produced video films which have been tested and found to be effective.

SLRTC-Karigiri has a video production unit which was partly funded by USAID. They have produced a large number of teaching aid films on leprosy for teaching purpose and can be asked to produce films on AIDS provided they are given technical help.

- 5.2 Apart from the traditional education methods, folk media has become very popular and effective. This includes street plays, Villupattu and Kathakalashepam. These methods have been used by NGOs for highlighting social issues. A few institutions have used it for health such as CDTR, MCCSS, CHAD-CMC, IPP-V.

This method has the advantage that the community is actively involved in the preparation and the presentation. Usually the youth of the community or some volunteers are responsible for the performance. The message will have to be provided by those with technical knowledge of the subject. This is then adopted according to local customs and practices.

5.3' Counselling:

Very few NGOs are providing counselling. Some of the NGOs who mentioned it as one of their activities were providing education only.

- 5.4 CMC Vellore has an organized AIDS counselling program. All patients diagnosed to be HIV positive attend a special clinic which is conducted once a week. The counselling team includes a social worker, psychologist or psychiatrist and clinician.

AIDS Research Foundation of India is providing counselling to commercial sex workers. It had to create a good rapport to win the confidence of sex workers before they started attending counselling programs.

- 5.5 Some NGOs have women legal aid cells which also provide counselling. Most of the problems are related to dowry, alcoholism, wife beating etc. Many of these women are at risk of acquiring STD/AIDS because of the life style of the couple. These NGOs which at present include ICCW, Women's Voluntary Service, YWCA, Khajamalai Ladies Association, Arulagam and Grace Kennet Foundation can also provide AIDS counselling after receiving adequate training. CMC Vellore can organize a series of training program with the help of the Christian Counselling Centre - Vellore which has been conducting counselling training program for over 15 years.
- 5.6 The first contact for help and advice at the community level are the community health volunteers (CHW) and health staff working at the community level. They provide some form of counselling. The training they require to improve their counselling abilities needs to be studied and the training module documented and disseminated. If the training is successful they will play an important role in counselling in the community and will reach out to a group which is unlikely to visit a professional.

## 6. Research

Research has been identified as an important component of this project. This includes rapid assessment, operations research and behavior research. Rapid assessment will be used prior to the commencement of some activities in order to ensure its relevance and feasibility of the intervention. Operation research will study the effect of the strategy used and help make mid project corrections. Behavior research will study knowledge, attitude behavior and practice and factors influencing these.

Most NGOs have a very good rapport and working relationship with the community and so are suited for doing such research they have not give priority to research of any form. The reasons are lack of funds, time and personnel. This project which will work through the NGOs needs to stress the importance of research to them. The findings of this research should be of value in planning future programs both for NGOs and the Government.

In view of the lack of technical knowhow among NGOs, some institutions will have to be selected for carrying out the research or for providing technical help.

Rapid assessment and operation research can be carried out with the help of the Schools of Social Work, Gandhigram Rural Institute for Health and Family Welfare, Tuberculosis Research Center Madras, CMC Vellore, Centre for Development Training and Research and SEARCH. Since the capability to do behavior research is poor it will have to be carried out with additional technical assistance to the Schools of Social Work and other institutions. This technical assistance can be provided by a group of consultants either from the state or other parts of India or if necessary overseas.

The modus operandi of the Center for Development Training and Research can be adopted namely tapping on appropriate consultants to design the study and to be implemented with the help of the school of Social Work or other institutions.

Epidemiologic and Statistical help can be provided either by the Tuberculosis Research Centre or CMC Vellore. These two institutions with its long history of carrying out community based epidemiological research and evaluation can be used as resource centers as well as for monitoring the programs. The CMC Vellore is carrying out 2-3 weeks courses in epidemiology and they could be asked to provide special courses to the NGOs and Schools of Social Work.

Yet another mechanism for doing behavior research is to request those institutions interested, to submit a letter of indent with a brief outline of the study. Based on the letter of indent, the institutions can be selected for a four day workshop where technical assistance will be provided for writing a detailed project proposal including the objectives, methodology sample size study design and analysis. They can then be asked to submit the proposal and the final selection be done based on this.

Research related to drug sensitive pattern can be done by MMC, Madurai Medical College, CMC Vellore or one of the other medical college and the results disseminated to the practitioners as soon as possible.

#### 6.1 Network

Some of the NGOS work as members of a network. Examples of established networking organizations are Family Planning Association of India, Voluntary Health Association of India, Christian Medical Association of India, and Catholics Hospital Association. Till now AIDS prevention has not been a priority for any of these associations.

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South Indian AIDS Action Program (SIAAP) and AIDS Research Foundation of India are recent organizations working exclusively for AIDS prevention. Even though SIAAP has not been registered as yet it has organized a few workshops for the NGOs. Working through networks has the advantage that a large number of small NGOs can be reached as evidenced in the workshop organized by SIAAP. Some NGOs have unipurpose activities and it may be impractical for APAC to work with them individually. Working with Networks also has the advantage that specific activities can be assigned to the smaller NGOs based on their expertise.

The network can also share their experience through a newsletter or workshops and thereby help each other. This was seen in the PVOH I project when all the sub-grantees came together for a meeting.

The disadvantage of a Network is that the nodal body may become too overpowering and thereby prevent the members from being flexible and innovative. The second disadvantage is that the administrative structure maybe financially expensive. To prevent this there can be a ceiling for administrative expenses of the nodal body (eg.7.5%)

1. Schools of Social Work

There are over 8 Schools of Social Work in Tamil Nadu. The following were visited.

a) Madras School of Social Work:

This was the earliest social work institution established in the State and has an intake of 40 students per year. In view of the large number of institutions which have been recently established, the intake is likely to be reduced so as to ensure job opportunities for those graduating from these schools. It has a graduate and postgraduate course. The Madras School of Social Work has been given several assignments by the State and Central Government for evaluating programmes such as the ICDS. In addition they have carried out in-depth studies in certain areas including behavioural studies of the industrial workers. The Madras School of Social Work in addition to the teaching programme also have project division which can appoint staff based on the need and the Director who is Incharge of the Projects is confident that he could tap on the resources of experts both in Tamil Nadu and in the neighbouring States to help carry out behavioural studies.

b. Stella Maris College:

The Department of Social Work was established in 1953. Initially they gave Diploma and from 1962 they give Masters in Social Work. They have 7 staff of whom 4 are Ph.Ds. They have an intake of 25 students per year who subsequently sub-specialised in medical psychology, family welfare and community medicine with approximately 10 in each group. They are directly involved in projects in three slums with funds received from Government. The funding has been discontinued. The Animators they trained are still available and have a good rapport with the community. They also work with Voluntary Agencies like Gramaltus in Leprosy, ICCW scheme, YWCA, etc. Stella Maris College has also been assigned research projects from Government and UNICEF which includes Working Womens Hostel, study on delinquency and most recently on the atrocities on women. An action based research proposal has been submitted for drug prevention and improvement of quality of life. The studies carried out by Stella Maris does not include an indepth study on behavioural changes. The reason attributed for this is such studies requires a lot of time and since the faculty members have teaching responsibilities, they have not been able to set apart time for this. They felt they are capable of doing this study with technical capabilities provided research staff are appointed for this purpose.

c) Loyala College:

It is an Arts and Science College with several departments

and Social Work Department is one of them. They work in close association with some of the NGOs such as women doctors association and have not taken any in-depth study on behavioural aspects.

d) Bishop Heber College:

This is an Arts and Science College with a Department of Social Work. It has got very young staff who are interested in doing research. At present their involvement in Social Work activities.

e) Sacred Arts College

The Department of Social Work of this college has got a large community based programme both in the town of Tirupattur as well as among tribal population of Jamunamaruthur. The emphasis of this department is also social work activities and research has not given much importance. The College has a research programme for students. They work closely with the CHAD programme, CMC, for the activities of the tribal area and have indicated an interest in carrying out collaborative research with them.

f) Madurai College:

Like Madras School of Social Work this is an institute of social work. They have several programmes and also carried out evaluations of Government programmes. One of their staff have selected AIDS as one of his subject for his Ph.D. They carry out social work activities in different communities including tribals. Like other institutions, behavioural research has not been given high priority but are interested in it.

g) Avinasilingam Deemed University:

The education programme of this university extends from primary school to doctorate. Initially it was primarily involved in Nutrition and it has now extended to Social Work. The institution has a large population where it provides service to 68 villages (40 kms from Coimbatore). They have an integrated programme provide agriculture information. The aim of their work is to take science to the village so that the community will improve their lifestyle. They also have job oriented training programme in the urban areas apart from being responsible for providing services in urban and rural areas. Their resources have been used by the Government for training of NSS Coordinators, Anganwadi teachers and community nutrition workers of the TINP programme. This institution has carried out evaluation programmes for the Government. In view of their experience in carrying out evaluation programmes, they could be used for monitoring some of the programmes in Coimbatore and neighbouring districts with technical assistance. It may be possible to use them for

providing training to NGOs in project preparation and implementation. They have over 200 faculty members of which 40 are Home Science in 20 disciplines.

2. Women Doctors Association:

It is a voluntary organization with the Head Office in Kilpauk Medical College. It has branches throughout the State. Their main objective is pre-marital counselling and education. They work in close association with the other voluntary organizations such as Indian Red Cross Society, Bharatya Sewa Samaj, Loyala College Social Work Department etc. They have shown interest in STD and AIDS prevention and control especially in areas of Information Education Communication and Counselling. Dr. Somini the former Director of the Venereology Department is a very committed and respected member of the profession and will be suitable for training general practitioners in STD management and counselling. The philosophy has been to provide service on a voluntary basis through their members and have never raised funds for any project. They would like to continue to function as true volunteers. However funds may be required for training material for organizing training programmes. They have experience of working with other organizations and this could be further strengthened. The strength of this organization is that being a women's organization they could contact women patients suffering from STD.

3. Centre for Development Research and Training:

Mr. Subramaniam is the Director of this organization. He held several senior positions in the State including Project Director DANIDA, Secretary task force of Human Resource and social change on economic development in addition to several programmes for Adi Dravidas and Tribal Welfare, Social Welfare and TINP. After opting for early retirement, he became a Consultant for several UN and other international agencies. This organization has established in 1984. They have completed over 50 projects in the areas of health, water shed development, agriculture, social forestry, socioeconomic and socio cultural studies and monitoring of programmes. The organization is able to get the resource persons from various parts of the country depending on the nature of the studies carried out. At present they are carrying out studies for the USAID on National Family Health Survey and on AIDS. The CFDRT could be an appropriate group for carrying out sociological studies as well as for monitoring the programme.

4. AIDS Research Foundation of India:

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Dr.Sundararaman is one of the few individuals who have worked directly with sex workers and the street children. He is a very committed person and has got a lot of experience in AIDS education and counselling. He has worked through industries, schools, colleges and also done studies of high-risk groups such as truck drivers and sex workers. Based on this, the State has introduced interventions namely education and condom distribution. He also work through Rotaract for educating the college students. The education programme he has organised includes Nemesis using a popular music group through which AIDS education was done and Jive Live. Dr.Sundararaman was initially working for ICMR and resigned from this as he found that he was not able to carry out AIDS prevention and control activities. He worked independently initially and has now registered a Society known as AIDS Research Foundation of India. He is well known both nationally and internationally for his work among the sex workers and is probably the only person in Tamil Nadu to work directly with the sex workers. For this he needed to create rapport with them and to be identified with one of them. In this process he was put under police custody on a few occasions till the police realised that he is working for the good of the sex workers. The thrust of his intervention is education and condom distribution. He has also produced T-shirts with messages on AIDS prevention. He has also worked with Journalists and Film Actors and Authors of short stories. He conducted a workshop for them so that they will be able to provide information to the public through their media. He also hope to open a telephone hot-line so that people could get correct information.

5. SOUTH INDIA AIDS ACTIVITIES PROGRAMME (SIAAP)

This groups is still to be registered. It has organized several workshops for the NGO's, especially the smaller grass-root NGO to create an awareness and to motive them to do AIDS prevention work. The office is presently in the VHS campus, Madras. They have a very committed group of people involved in AIDS education. Their activities include education of the mass media personnel. The intervention programme includes education and distribution of condoms to truck drivers. They are considering the formation of a Network of NGOs involved in AIDS prevention work.

6. IPPV Project:

The entire city of Madras has been covered with the IPPV project. It has 120 health posts of which 106 are functioning. Of those 106, 25 have been earmarked for PVOs or NGOs. Each health post is provided with staff which includes a lady medical officer, lady health visitor, public health multipurpose worker, family assistants and also 15 zonal centres with additional staff. At these centres MTP and deliveries are carried out.

Nearly 12000 deliveries are conducted in all the health posts which accounts of 25% of all the deliveries. The activities of the IPPV project includes MCH, family planning, information education communication. They conduct health camps in the various urban communities through target groups (those who live below the poverty line). They have already produced several health education materials and also done health education using Villupattu and folk-media. They plan to carry out counselling at a later stage. Nirodh is distributed as part of the family planning programme but they have expressed their opinion that they could use their centres for prevention of AIDS and STDs. The zonal centres are suitable for providing holistic care which includes MCH services and counselling for those with STD and other problems. The NGOs working in the IPPV project could be classified into three groups those which are very good, those which are just average and a few which are not upto the expected levels. Those who are doing good work in the IPPV project could be used for AIDS education.

7.

MADRAS MEDICAL COLLEGE  
Poonamale High Road, Madras.

The Madras Medical College is the oldest medical college in Tamil Nadu. It has a strong STD and Microbiology Department which is actively involved in AIDS prevention. The first HIV positive case was identified through MMC. It established an AIDS control programme. The activities of this includes health education and training in laboratory procedures. With the limited funds available they have organised education programme. They also publish and circulate a newsletter and organized education programme on Television. To increase the awareness among college students, an intercollegiate competition was conducted on various aspects of AIDS. To ensure that the mass media projects the problem of AIDS scientifically a workshop was conducted for the media persons. Laboratory technicians from various parts of Tamil Nadu have been trained in HIV screening.

8.

GUILD OF SERVICE  
28 - Casa Major Road, Egmore, Madras 600008.

The Guild Of Service was established in 1924. It has 27 units and 36 branches statewide. The Guild Of Service has a large number of activities which includes

- Care of children (residential)
- Seva Samajan childrens home
- Seva Samajan girls home - age 8-20
- Seva Samajan boys home - age 10-20
- Bal Bhawan boys home - for payment leveller
- Thatikonda Rajamanner home

- education programmes
- health and family planning
- service to handicapped
- socio-economic programme
- Welfare for women and aged - working women hostel
- family development (international project) with family development, rehabilitation of women and care of children and opportunity for income generation.

Some of these activities can be used for the APAC project especially Bal Bhawan boys home and the family development project.

9.                    MADRAS MANAGEMENT ASSOCIATION - MMA  
68 Nungambakkam High Road, Madras 600034.  
Tel. : 475800; 478311

This was established in 1956. There are 828 members. This includes 352 institutional members and 264 individual members. The activities of the MMA includes - education for Executive and Managers through workshops and special lectures. They have a video cassette library. Industries use these video tapes for education of their workers and managers. They have organised several educational programmes with the help of DESH.

10.                  INDIAN COUNCIL FOR CHILD WELFARE (ICCW) - TAMIL NADU  
5, 3rd Main Road, West Shenoy Nagar, Madras 600030.

This is an all Indian organisation. It has activities in various parts of the State. The activities of ICCW are given below. Many of them can be used for APAC.

- Community Counselling
- Creches
- Rehabilitation Centre for handicapped
- Home for destitute children
- Usilampath project for women and children with emphasis on prevention of female infanticide.
- Child labour project in Vellore.
- Street children programme (200 rag pickers)
- Training Centre for child care works (100/year)
- ICDS supervisors

11. CONGREGATION OF THE SISTERS OF THE CROSS OF CHAVAPOD (SOCSEAD)  
P.Box 395, Old goods shed road, Teppakulam,  
Tiruchirapalli 620002.  
Tel. : 31514

This was established in 1982. The aim of the organization is the socioeconomic and human development of the disadvantaged and marginalised sections of the population. Their motto is " To love is to achieve To serve is to Love".

The activities includes

- Employment and economic programmes
- Education - adult, nonformal, vocational
- Health and sanitation, Mini PHC
- Community Development
- Welfare - counselling for drug addicts  
family counselling short stay home for women  
and adoption services.

This organization also focuses on vulnerable groups in Tiruchy and the APAC project can be effectively implemented by them.

12. ASSOCIATION OF ARULAGAM  
(THE HOME OF GRACE)  
Arulagam, Pasumalai, Madurai 4.

This was established in September 1975. Women rescued from brothels, destitute home and prison are kept here and provided education and vocational training. 414 have been admitted todate, 187 have gone back to their parents, 24 married through the efforts of Arulagam and 54 women and 18 children still present in Arulagam.

13. MARIE STOPES  
28, Defence Colony Market, New Delhi 110024.  
Tel : 617712 ; 619024.

Parivar Seva Sanstha (PSS) provides an integrated MCH & FP services and reproduction health. It has clinics in various cities including Madras. An integrated FP, MCH and reproductive health services is provided under the same roof. Counselling is also provided. General Practitioners refer patient to them for these services. Social marketing of contraceptive is carried out by them in a big way in the northern States.

14. KHAJAMALAI LADIES ASSOCIATION  
Khajamalai, Trichy 23.  
Tel. : 59655

They provide service to the villages around Trichy (population 20,000) and the slums of Trichy. The activities include:

- A mini-health centre
- Child care activities
- Family welfare motivation camp
- Socioeconomic programme - garment knit, Zari Work, Embroidery.
- Free legal aid
- Family counselling
- National adult education programme
- De-addiction hospital and a counselling centre

Education can be provided to the girls working in the handicraft unit, those undergoing vocational training and especially to those in the de-addiction programme. The counselling activities can be improved to include AIDS/STD.

15. ASHA NIVAS  
9 Rutland Gate, 5th Street, Madras 600006.  
Tel : 479311 ; 478606.

This was established in 1976 to cater to socially, physically and intellectually handicapped from slums of Madras city. The activities of Asha Nivas are -

- Vocation training and employment oriented programmes
- Tailoring, embroidery
- Leather handicraft
- Balwadis
- Non-formal education programme  
Children between 7-14 years who are employed in various capacities.
- Rag pickers development project  
Community health and nutrition programmes (1000 women & children)  
Self-employment scheme through Madhar Sangam such as small business and trade for over 2000 people.

16.                   MADRAS CHRISTIAN COUNCIL FOR SOCIAL SERVICE  
                          158 Wall Tax Road, Madras 600003.  
  Tel : 564451

This was established in 1965. The activities listed are :

- Development education
- social development is an integral part of these activities. It aims at conscientisation of the poor and exploited and to motivate them to participate efficiently and meaningfully into their struggle to bring about the cherished social change.
- Community participation is an essential part of their program. The women movement is channeled through Madhar Sangam (women clubs) seminar and training camps.
- self employment activities includes tailoring unit, candle making, payment vendors association
- Education programme includes adult and non formal education, street play for general education and awareness creation.
- Improvement of environmental sanitation through house construction, smokeless choolas and low cost latrines
- Health care by conducting clinics with MMC and IPP-V
- Counselling especially for marital discord, family disharmony and physically handicapped.
- Field counselling - mental problems etc. in the community.

They have a special STD clinic in the slums. The Staff from MMC provide the technical support.

17.                   GRACE KENNETT FOUNDATION  
  Madurai

This was started in 1981. Activities of Grace Kennett Foundation includes:

- Community based health care
- hospital services
- womens development
- child development
- community workers training programme

They work both in villages (population 10,000) and a small slum community where their staff resides. The child welfare includes care of abandoned children. The community workers trained in this centre are helping in the ICCW project for prevention of female infanticide.

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18. DEEPAM EDUCATIONAL SOCIETY FOR HEALTH (DESH)

This is a society registered recently with the main objective of providing education especially on AIDS. They are working with Madras Management Association. They organize education programme for industrial workers and managers. They also provide counselling.

19. TAMIL NADU NGO FORUM FOR STREET AND WORKING CHILDREN  
6, I Cross Street, Lake Area, Nungambakkam, Madras.  
Tel. : 867830

10 organizations in Tamil Nadu including 6 from Madras city are members of this forum. The purpose of the forum is to organize collective action to tackle the problem of street and working children and to share experiences and offer guidelines and promote spirit of cooperation and collaboration with Government and other NGOs.

Till now they have organized seminars and awareness creation programme through street rally and leadership camp for street children.

20. CHRISTIAN MEDICAL COLLEGE (CMC)  
Bagayam P.O., Vellore 632002.  
Tel.: 22603

A large teaching hospital with all specialities. Provides health care at primary, secondary and tertiary level. The primary health care programme cover over 200,000 population in a rural, urban and tribal areas and is ideal for operational research. Has a well established Virology Lab. The first HIV positive test was done here. Over 36 cases of AIDS have been admitted and treated here. A special ward for the AIDS patients has been set up! All HIV patients are given pre and post test counselling by a team of doctors, social worker and psychologist. The community based education for AIDS has just begun using folk media. This activity is integrated with other primary health care activities. The psychiatry department is conducting a series of education programmes for teachers, medical practitioners and community leaders and health professionals. The institute has a large history of carrying out community based research. It has a strong Biostatistics and Epidemiology Resource Centre which conducts training programme for staff of other medical institutions in research methodology.

21. VOLUNTARY HEALTH SERVICE  
Adyar, Madras.

This was established three decades ago one of the largest and well respected NGOs. The Director of the Voluntary Health Service Dr. Sanjeevi was the initiator of the Mini-PHC scheme in Tamil Nadu. He also started a Health Insurance Scheme for the poor people in and around Adyar. They have an extensive primary health care programme which covers parts of Madras city and more than one block of Chengelpet District. They have two MCH clinics under the IPPV project as well as leprosy and tuberculosis control programme. They have not given priority to AIDS prevention as yet but have shown interest. They have provided office space for the SIAAP.

22. CENTRAL BOARD FOR WORKERS EDUCATION

This is a Central Government programme involving the Trade union, State Government and Management. Each industry identifies a worker teacher who is provided a three months training on various aspects of industrial laws and regulations. The worker education then give training to their co-worker thereby ensuring that all the workers are educated about labour laws, industrial laws, national safety council and about preventive programmes.

23. CSI COUNCIL FOR HEALING MINISTRY

This is an organization of the Church of South India. The aim of this association is to create an awareness among the church members on their role in the healing ministry. They organized a series of programmes to make Pastors and church leaders aware of the various aspects of the healing ministry. They have organized community health workers in certain communities and also have counselling programmes for college students. The Church of South India (CSI) has a large number of hospital throughout Tamil Nadu and this can be used for improving the STD treatment and condom distribution.

24. YOUNG WOMENS CHRISTIAN ASSOCIATION

This was one of the oldest Non-Government organization in Madras and has got a variety of programmes which includes adult education, income generating programmes, mini health centres and counselling for underprivileged women. They have short-stay transit centres. APAC can be implemented through these activities.

## ADMINISTRATIVE ASSESSMENT OF VOLUNTARY HEALTH SERVICES

### 1.0 INTRODUCTION:

Voluntary Health Services (VHS) will be the principal implementing agency for the AIDs Prevention and Control Project. VHS will implement the project through a separate project cell, which will provide subgrants to NGOs for project interventions and for NGO support and research. VHS is a society registered under the Societies' Registration Act XXI of 1860 and works for the prevention, control, treatment and relief of human disease by the establishment of plans for rendering free and charitable service or aid to the poor, needy, distressed or disabled. VHS is a large reputable health care NGO situated in Madras that has been operating since 1958. It is sustained through donor funds, private donations, some fee-for-service activities, and interest earning on endowment funds. VHS has been operating a 300 bed hospital and has also been implementing community health projects funded by the Central Government, the State Government and international donors.

### 2.0 VHS MANAGEMENT AND STAFFING:

VHS is managed through a Board of Trustees comprising of 9 members and a Central Committee of 55 members comprising of major donors, the Advocate General (Tamil Nadu), the Collector of Madras, Chairman - Madras Chamber of Commerce and Industry, and Senior staff members. Although all major decisions related to VHS are approved/ratified by the Central Committee, VHS has made limited delegations of authority to five subcommittees namely finance, administration, appointments, accounts and planning. The delegation of authority for contracting and payments is centralized with the Secretary of the Central Committee. An organizational chart of VHS is appended as Attachment 'A'.

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As of the date of review, VHS has a strength of 272 employees (administrative staff 28, paramedical staff 164, medical staff 80). In addition to the aforementioned staff, VHS also receives voluntary services of medical professionals on part time basis.

### 3.0 VHS' CAPABILITY TO MANAGE APAC:

The APAC project is the biggest activity that VHS has ever been tasked with and therefore it presently has very limited capability to handle a project of this magnitude. The project designers realized this limitation in their early assessment of VHS and accordingly recommended that the project cell should comprise of Project Director, IEC Specialist, Research Specialist, Condom Logistics Specialist, and STD Specialist.

In addition to the aforementioned staff, VHS needs to establish a structure of subcommittees for monitoring implementation of NGO grants and other components of the project. For the purpose of monitoring, VHS will need at least two professionals during the early phase of the project and the need may increase to four by the middle of the project. Therefore, VHS needs to hire a Project Director, four Program Specialists and two Monitoring Assistants to carry out technical responsibilities for implementing and monitoring the APAC Project.

As regards the financial capability, VHS has adequate staff to do book keeping transactions on manual records with negligible budgeting requirements. However, the accounting staff is not capable of carrying out financial monitoring of disbursements made to subgrantees. This type of a financial set up will not be adequate to handle financial transactions to the tune of \$1.5 million per year and to comply with various A.I.D. requirements. Therefore, it is suggested that the project cell be staffed with at least two accountants (preferably Chartered Accountants), who will be assisted by a firm of reputed Chartered Accountants to carry out their regular financial monitoring, accounting and reporting responsibilities for more than 100 NGOs in the State of Tamil Nadu. The accountants in the project cell along with the firm of

Chartered Accountants will also ensure compliance with the A.I.D. audit requirements. The accountants in coordination with a software consultancy firm will have to establish a computerized accounting, budgeting and reporting system to keep track of the project funds.

VHS has an adequate administrative set up to run a hospital and minor health projects funded by the Central and the State Government. For the purpose of managing the administrative and procurement actions of the APAC project, VHS will need to draw upon the services of one of the accountants hired for financial monitoring of the subgrantees. In addition to part time administrative services of the accountant, VHS might have to use services of a Management Consultancy Firm to carry out any complex contracting actions under the project (Refer to Section 5.0 for details on procurement capability).

Issues:

1. Pay scales of VHS are very low as compared to the market wage structure and are not attractive for qualified professionals. Therefore, it is recommended that the Project Paper as well as the Cooperative Agreement should make provision for recruiting the project staff on the basis of at least the Central Government pay scales. This issue was discussed with Dr. Rao, Additional Director, Community Health who informed the assessment team that varying wage structure within his organization is an acceptable practice and there are already some project funded activities which are financing pay scales higher than that of VHS. (VHS wage structure is appended as Attachment 'B').

2. VHS alongwith USAID should work out a structure of subcommittees for effective functioning of the project in areas of subgrant appraisal and approval (addressed by PP), financial and technical monitoring of subgrant activities, and contracting.

3. Initially there was a proposal by VHS to appoint a part time Project Director (need based contribution to the project) for the APAC project cell.

However, later on the Project Officer has been given to understand that the Project Director being proposed by VHS will contribute atleast 80% of his time to the project. Realizing the importance of the Project Director in successful implementation of the project and magnitude of the project both in terms of funds as well as the geographic spread within Tamil Nadu, the Project Director should ideally make a full time contribution to the project.

#### **4.0 INFRASTRUCTURE:**

VHS proposes to construct a separate section measuring 4,000 square feet for providing office space to the project cell, which as per VHS will be ready in about three months. VHS has assured that any delay in construction plans will not effect the project as an alternative temporary office space can be arranged within their hospital premises. The project has budgeted for the equipment required to computerize the project operations and to build up necessary communication linkages through fax.

#### **5.0 PROCUREMENT AND CONTRACTING STANDARDS:**

The following procurement procedures are followed by VHS for capital and revenue procurements:

As capital procurements of VHS are mostly met out of donations, these are in the nature of non budgeted expenditure. Subsequent to acceptance of donation by the Central Committee, quotations are invited from competent suppliers. The quotations received are appraised and rated by the Medical Superintendent and are recommended for award of contract to the finance subcommittee for approval. On receipt of approval, the contract is awarded to the vendor through exchange of letters. Capital equipment is received and verified by the requesting department under intimation to Stores. The Stores department on receipt of bill and approval from the technical department forwards the bill to the Lay Secretary, who in turn forwards it to the Medical Superintendent for his approval. After approval of the Medical Superintendent the bills are forwarded to the accounts department for processing of payment,

which is finally signed by the Secretary and the Treasurer. During the assessment, procurement documentation was verified for compliance with the stated procedures and it was observed that in many cases quotations were invited from a single supplier and capital requirements were rarely advertised for open competition.

Procurements of expendable items are controlled by an annual budget exercise. The budget is prepared by adjusting the previous year expenditures to current inflation and approved by accounts subcommittee. Subsequently the budget is ratified by the Central Committee. For expendable items approved in the budget, the individual units place their requests/demands on stores, which are appraised by two medical officers and recommended for procurement. Quotations are invited from a standard list of suppliers and appraised in the manner similar to that of capital equipment.

VHS lacks capacity to undertake direct overseas procurement of equipment, however they can procure imported equipment through local representatives of overseas firms. Furthermore, VHS lacks capacity to process documentation for import of equipment and undertake its clearance from customs. Therefore, if the project envisages procurement of imported equipment directly from the U.S., USAID or a procurement agent would have to undertake such procurement.

Comment: Although integrity of the procurement system is not questionable, there is lack of structured controls to ensure competition and economy of prices. Furthermore, VHS seemed to lack capability to carry out technical and large scale procurement of non medical items. Therefore, it is suggested that for any technical and major contracts envisaged in the project, VHS should be assisted by a Management Consultancy Firm for identification and selection of possible contractors/suppliers.

Issue: Despite being a lead NGO in the State of Tamil Nadu, VHS has limitations regarding its procurement and contracting procedures and similar situation may be expected of the other NGOs operative in Tamil Nadu which will receive subgrants from VHS. Therefore, it is recommended that the project

cell should concentrate on procurement plans for all NGOs and initiate a centralized procurement at VHS through a Management Consultancy Firm for further distribution to subgrantees. It is expected that for IEC, the subgrantees may need to procure audio visual equipment and display materials.

#### 6.0 OTHER HEALTH PROJECTS HANDLED BY VHS:

The objectives and magnitude of some of the projects handled by VHS are given below:

1. Dr. A. Lakshmi pathi Research Unit for Indian Medicine (ALRUIM): Under this project VHS receives a grant of approximately Rs. 500,000 (\$16,666) per annum from the Central Council for Research in Ayurveda and Siddha for doing research in Ayurvedic medicine using modern medical concepts.
2. Center for Protein Engineering and Biomedical Research: Under this project VHS has received a grant of approximately Rs. 8,500,000 ( \$283,333) from the Department of Science & Technology for a five year period (second year in progress) to carry out research on synthesis of chemical cross linkers which stabilize enzyme proteins.
3. Urban Health Posts: During FY 1990-91, VHS received a grant of Rs. 224,000 from the State Government (World Bank funded) for maintaining two health posts to provide health services for mother and children and to carry out family welfare activities.
4. PVOH-I Project: This USAID funded project entitled "Control/Eradication of Leprosy and Tuberculosis through primary health care delivered through Mini Health Centers" was sanctioned in 1984 for a period of six years. The project provided comprehensive primary health care, nutrition and family welfare services through the infrastructure of Mini Health Centers and integrated TB and Leprosy Control with it thereby making it a horizontal program covering about 200,000 population in rural areas of St. Thomas Mount and Thiruporur Panchayat blocks besides covering part of urban slum population. Against an

approved grant of Rs.11.29 million (\$376,000) for a six year period, VHS utilized Rs.11.23 million (\$374,000).

In addition to the aforementioned projects, VHS had received following grants during IFY 1990-91.

**From Tamil Nadu Government:**

- |  |                         |
|--|-------------------------|
| i) Building Construction from Indian Population Project. | Rs.1,018,000 (\$33,933) |
| ii) For Maintenance of Madras Race Club Hospital.        | Rs.1,754,160 (\$58,472) |
| iii) Subsidy for diet, drugs etc. on Family Planning.    | Rs. 39,000 (\$ 1,300)   |
| iv) For Community Health Project                         | Rs. 424,463 (\$14,149)  |

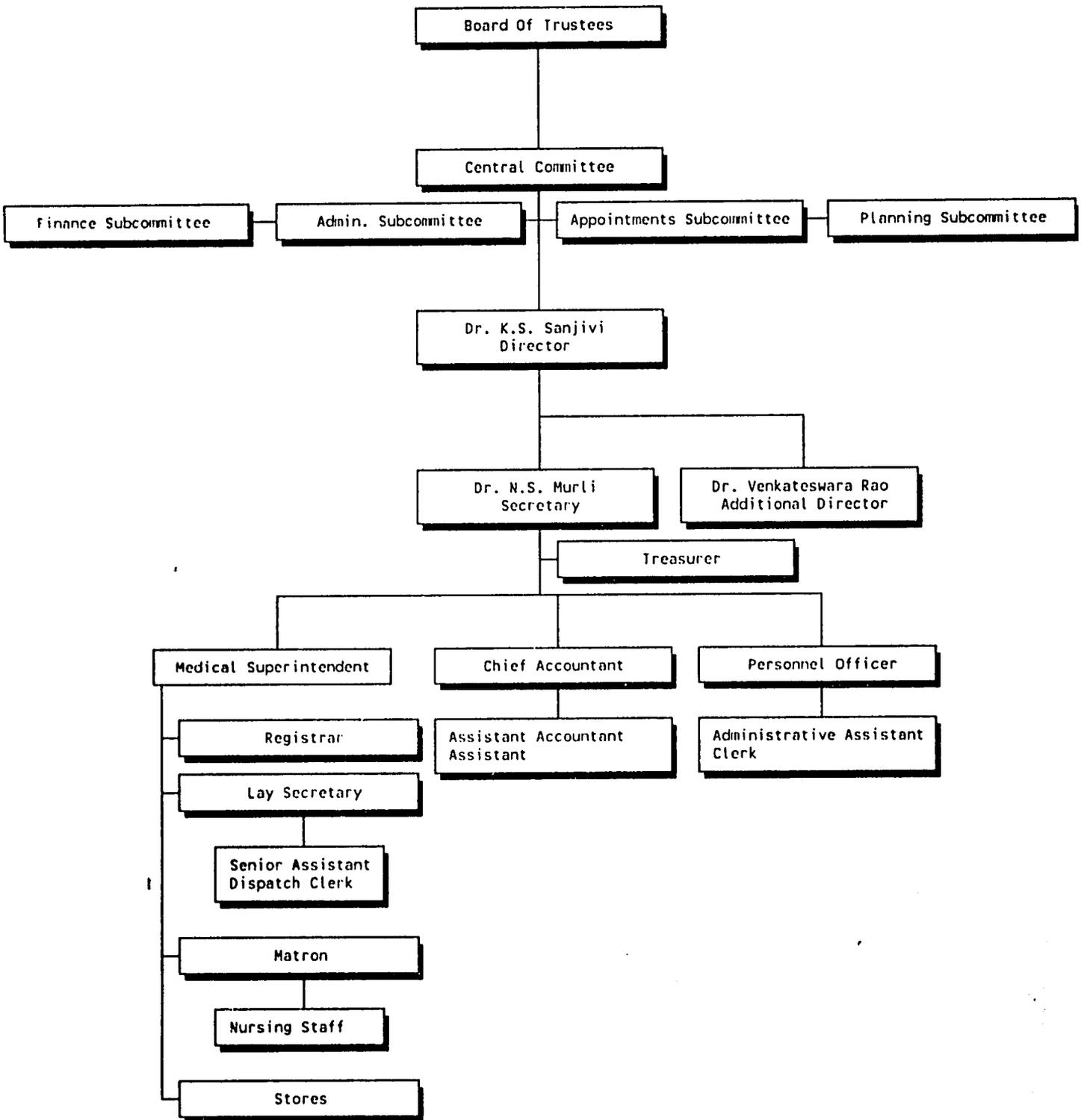
**From Government of India:**

- |  |                       |
|--|-----------------------|
| i) Ministry of Environment & Forests Research on Ecology and Environment | Rs. 60,129 (\$ 2,004) |
|--|-----------------------|

**7.0 CONCLUSION:**

VHS has the infrastructure and technical links with NGOs to implement the APAC project, however, it will be necessary for the project to help VHS in developing programmatic and financial expertise for coordinating project activities through other NGOs. Furthermore, USAID needs to assist VHS through Management Consultancy Firms to develop administrative expertise in the areas of contracting and data base management.

VHS ORGANIZATION CHART



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## THE VOLUNTARY HEALTH SERVICES ADYAR MADRAS 113

ANNEXURE I TO OFFICE ORDER NO.76 DATED MAY 11, 1990REVISED PAY SCALES EFFECTIVE FROM 01 APRIL 90

<u>Scale Code No.</u>	<u>CATEGORY</u>	<u>REVISED SCALES OF PAY</u>
1.	Medical Superintendent	1300-60-1600-80-1920-90- 2370-1000-2970
2.A.	Resident Medical Officer Registrar Full time Medical Officer	1150-50-1400-60-1640-70- 1990-80-2470 Note: 2A on completion of 15yrs service will be placed on scale Code No.1
2.B.	Lay Secretary Accountant Nursing Superintendent	1150-50-1400-60-1640-70-1990- 80-2470
3.	Selection Grade Radiographer Senior Biochemist Senior Laboratory Asst	900-35-1075-40-1235-45-1460- 50-1760 Note: On completion of 15 yrs service will be placed on scale Code No.2
4.	Head Nurse	900-30-1050-35-1190-40-1390- 50-1690
5.	Staff Nurse	825-25-950-30-1070-40-1270- 50-1570
6.	Radiographer Physiotherapist Refractionist Photographer Lab.Asst(Graduate) EEG Technician Biochemist Asst Electrical Supervisor Administrative Asst Dietitian	750-25-875-30-995-40-1195- 50-1495
7.	Asst.Accountant, Librarian Senior Assistant	600-25-725-30-845-40- 1045-50-1345
8.	ANM, Nursing Asst, MPHW	525-15-600-20-680-30-830-35- 1040
9.	Junior Asst, Theatre Asst Assistants(Theatre/ICU/AKU ACV/ACC)Electrician(qualified) Social worker, Lab.Technician (Non.graduate)Dark Room Asst Stenographer, Storekeeper, Cashier Pharmacist, Compounder, AC Plant, Mechanic, AC Assistant	450-15-525-20-605-30-755-35- 965
10.	Driver, Hospital worker(with Nurse Aid qualification)Plumber Attender(Telephone/Office)	350-7-385-15-445-25-570-30- 750
11.	Hospital worker/Sweeper, Head Cook, Kitchen Helper, Gardener Electrician(not qualified) Stretcher Bearer, Attender	320-7-355-15-415-25-540-30- 720

*Handwritten signature*

THE VOLUNTARY HEALTH SERVICES (REGISTERED), MADRAS 600 113  
 ANNEXURE 2 TO OFFICE ORDER NO. DATED MAY 11, 1990  
 Revision of Allowances to Employees of Voluntary Health  
 Services Effective from 01 April, 1990

\*\*\*\*\*

- |  |     |                    |
|--|-----|--------------------|
| 1. House Rent Allowance (HRA)  |     |                    |
| a. Revised Scale Code Nos.<br>1- 9 Other than Nursing<br>Staff                     | ... | Rs.40/- p.m.       |
| b. Revised Scale Code Nos.<br>10 and 11  | ... | Rs.30/- p.m.       |
| 2. Ration Allowance<br>(To Nursing Staff only)                                     |     |                    |
|  | ... | Rs.50/- p.m.       |
| 3. Washing Allowance<br>(To Nursing Staff only)                                    |     |                    |
|  | ... | Rs.20/- p.m.       |
| 4. Store Allowance<br>(To Store Keepers)   |     |                    |
|  | ... | Rs.50/- p.m.       |
| 5. Emergency Call Allowance  |     |                    |
| a. Residing in VHS<br>Accommodation  | ... | Rs.15/- per diem   |
| b. Not residing in VHS<br>Accommodation - When<br>Called on Emergency &<br>Holiday | ... | Rs.30/- per diem   |
| 6. Uniform Allowance (To Nursing<br>Staff only)                                    |     |                    |
| a. Matron/Head Nurses  | ... | Rs.250/- per annum |
| b. Other Nursing Staff   | ... | Rs.225/- per annum |
| 7. Typing Allowance  |     |                    |
|  | ... | Rs.40/- p.m.       |

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*MGM*

## ANNEXURE 2 A

THE VOLUNTARY HEALTH SERVICES (REGISTERED) TTTI POST MADRAS 113  
 REVISION OF ALLOWANCES TO DOCTORS EFFECTIVE FROM  
 01 APRIL 1990

- |  |     |                    |
|--|-----|--------------------|
| 1. House Rent Allowance (HRA)<br>For Full time MOs   | ... | Rs.45/- per mensem |
| 2. Doctors' Special Visit  | ... |                    |
| a. Specialist/Consultant   |     | Rs.50/- per visit  |
| b. Assistant MOs   | ... | Rs.30/- per visit  |
| 3. Senior House Surgeons   | ... | Rs.1,250/- p.m.    |
| 4. CONVEYANCE ALLOWANCE TO<br>DOCTORS<br>(PART TIME DOCTORS ONLY)<br>Rs.25/- per visit of 3 hours duration   |     |                    |
| 6 days in a week   | ... | Rs.600/- p.m.      |
| 5 days in a week   | ... | Rs.500/- p.m.      |
| 4 days in a week   | ... | Rs.400/- p.m.      |
| 3 days in a week   | ... | Rs.300/- p.m.      |
| 2 days in a week   | ... | Rs.200/- p.m.      |
| 1 day in a week  | ... | Rs.100/- p.m.      |
| 5. NIGHT DUTY ALLOWANCE  |     |                    |
| a. Full Time M.Os.   | ... | Rs.35/- per duty   |
| b. Honorary Doctors  | ... | Rs.60/- per duty   |
| 6. TENURE ALLOWANCE  |     |                    |
| Medical Superintendent   | ... | Rs.200/- p.m.      |
| 7. Resident Medical Officer<br>Non Practicing Allowance<br>during tenure   | ... | Rs.200/- p.m.      |
| 8. Full time Medical Officers with post graduate<br>qualification will be granted one increment either<br>on induction or on fitment into the revised scales<br>of pay effective from 1.4.90 |     |                    |
| 9. Afternoon Medical Officers Special Allowance -Rs.100/-<br>per mensem  |     |                    |

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FINANCIAL CAPABILITY ASSESSMENT OF VOLUNTARY HEALTH SERVICES

A review was made to determine that the implementing agency, Voluntary Health Services (VHS), has financial management systems and personnel in place to assure adequate accountability of A.I.D. assistance totalling about \$9.6 million to be provided under the Project. We found that VHS' existing accounting system is generally adequate for its current operations but it will need to be strengthened to enable it to meet A.I.D. requirements and efficiently account for the large assistance contemplated under APAC.

Background: VHS is a private voluntary organization registered under Societies Registration Act, 1860, and it is engaged in the preventive and curative aspects of medicine. It is located in the city of Madras in the State of Tamil Nadu. VHS is an umbrella organization which runs a 320-bed hospital along with support services such as X-ray, laboratory, operation theater, etc. In addition, it also implements projects in the areas of medicine and community health funded by the Central and State Governments of India and private donors.

VHS' main sources of income are collections from the hospital, grants from the Central/State Governments, donations from private donors, and interest income from its investments.

Whilst the projects implemented by VHS are self-sustainable activities, the operations of the hospital are not. The annual average occupancy of the hospital is 180 beds with a ratio of paying versus free patients of 7:3. The operating deficit of the hospital, which amounted to Rs.1.9 million during the fiscal year 1990-91, was met out of collections from support services, grants from the State Government, and interest income from its investments.

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The overall fund position of VHS is strong. It has capital reserves of Rs.28.7 million and an Endowment Reserve Fund of Rs.13.8 million represented by assets of Rs.24.5 million and an investment portfolio of Rs.13.3 million. VHS as a policy endows all its donations and meets its recurrent expenses only out of interest income leaving the capital intact. This conservative policy has facilitated VHS to build up large reserves and control expenditures through conscious efforts. There is no commingling of project funds and operating income.

All projects implemented through VHS are treated as independent activities and carried out as per the terms of the related grant agreements. Separate implementation cells are created for each of these projects which are responsible for their programmatic and financial management. VHS maintains centralized books and records for these projects but has little or no role in their implementation nor does it receive any management fee or overheads.

Financial Systems and Records: VHS maintains a centralized manual accounting system under which separate records are kept for the Hospital, the Society, and the project activities. Although this system identified the sources and application of funds, it could not be considered satisfactory from the standpoint of generally accepted accounting principles. For example, there are no written policies regarding the treatment of donations/grants, segregation of expendable and non-expendable properties, creation of revenue reserves, valuation of stores, and valuation of gifts/donations in-kind. There is no segregation of duties as a result of which functions such as accounting, procurement, collection, voucher payments, and reporting are being performed by the same staff members. VHS also does not have a budgeting and management information system in place to enable the comparison of outlays with expenditures, generation of data relating to accruals, projection of funds

required for operations, and preparation of data needed for effective financial management.

Thus improvements will be required in VHS' existing financial systems and controls to bring them in conformance with generally accepted accounting principles so that they meet the stringent requirements of A.I.D. funding and provide the assurance that the assistance is being effectively used for authorized purposes. This is particularly important in view of the types of activities planned under the project, including the large number of subgrants, which would require effective financial controls, management and oversight. To ensure that A.I.D. assistance is used and accounted for properly, the Mission will provide funds for the services of a CPA firm to develop acceptable financial systems and controls and to train VHS's staff in their use before commencement of project implementation. The Mission will also provide funds for augmenting VHS' accounting staff. In addition, our Financial Analysts will be actively involved in the early stages of project implementation to review the adequacy of the systems developed by the CPA firm and their application by the VHS staff, and to explain A.I.D. policies and requirements to them.

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## APPENDIX 4A

## SAMPLE FORMAT

Mr. John Doe  
President  
XYZ, Inc.  
Anywhere, U.S.A.

Subject: Grant No. \_\_\_\_\_

Dear Mr. Doe:

Pursuant to the authority contained in the Foreign Assistance Act of 1961, as amended, the Agency for International Development (hereinafter referred to as "A.I.D." or "Grantor") hereby grants to the XYZ, Inc. (hereby referred to as "XYZ" or "Grantee"), the sum of \$\_\_\_\_\_ to provide support for a program in \_\_\_\_\_, as described in the Schedule of this grant and the Attachment 2, entitled "Program Description."

This grant is effective and obligation is made as of the date of this letter and shall apply to commitments made by the Grantee in furtherance of program objectives during the period beginning with the effective date and ending \_\_\_\_\_.

This grant is made to the XYZ, Inc., on condition that the funds will be administered in accordance with the terms and conditions as set forth in Attachment 1, entitled the Schedule, Attachment 2, entitled "Program Description," and Attachment 3 entitled "Standard Provisions," which have been agreed to by your organization.

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Please sign the original and each copy of this letter to acknowledge your receipt of the grant, and return the original and all but one copy to the Office of Procurement.

Sincerely yours,

\_\_\_\_\_  
Grant Officer

Attachments:

1. Schedule
2. Program Description
3. Standard Provisions

ACKNOWLEDGMENT

XYZ, Inc.

BY: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

FISCAL DATA

Allocation: \_\_\_\_\_  
Appropriation: \_\_\_\_\_  
Budget Plan Code: \_\_\_\_\_  
PIO/T No.: \_\_\_\_\_  
Project No.: \_\_\_\_\_  
Total Estimated Amount: \_\_\_\_\_  
Total Obligated Amount: \_\_\_\_\_  
DUNS No.: \_\_\_\_\_  
IRS Employer Identification Number: \_\_\_\_\_

Funding Source:

A.I.D./W

USAID

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## APPENDIX 4B

SAMPLE FORMAT  
SCHEDULEA. Purpose of Grant

The purpose of this Grant is to provide support for (state title of program or project), as more specifically described in Attachment 2 to this Grant entitled "Program Description."

B. Period of Grant

1. The effective date of this Grant is \_\_\_\_\_. The expiration date of this Grant is \_\_\_\_\_.

(For incrementally funded grants add the following sentence:)

2. Funds obligated hereunder are available for program expenditures for the estimated period \_\_\_\_\_ to \_\_\_\_\_ as shown in the Grant budget below.

C. Amount of Grant and Payment

(For fully funded grants use the following:)

1. A.I.D. hereby obligates the amount of \$ \_\_\_\_\_ for purposes of this Grant.

2. Payment shall be made to the Grantee in accordance with procedures set forth in Attachment 3 - Standard Provision entitled "Payment \_\_\_\_\_." (Select a method of payment in accordance with the applicability requirements set forth in the Standard Provisions, i.e., letter of credit, advance payment, or reimbursement.)

- or -

(For incrementally funded grants use the following in lieu of the above:)

1. The total estimated amount of this Grant for the period shown in B.1 above is \$ \_\_\_\_\_.

2. A.I.D. hereby obligates the amount of \$ \_\_\_\_\_ for program expenditures during the period set forth in B.2. above and as shown in the Financial Plan below.

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3. Payment shall be made to the Grantee in accordance with procedures set forth in Attachment 3 Standard Provision "Payment \_\_\_\_\_", entitled "Payment \_\_\_\_\_" (Select a method of payment in accordance with the applicability requirements set forth in the Standard Provisions; i.e., letter of credit, advance payment, or reimbursement.)

4. Additional funds up to the total amount of the grant shown in C.1 above may be obligated by A.I.D. subject to the availability of funds, and to the requirements of the Standard Provision of the Grant, entitled "Revision of Financial Plans."

#### D. Financial Plan

(The items included in the Financial Plan, including local cost financing items, should relate to the activities or functions described in Attachment 2 - Program Description, and should not be set up on the basis of cost element line items. This will facilitate the financial reporting requirements and use of the reporting form, SF-269.)

The following is the Grant Budget, including local cost financing items, if authorized. Revisions to this budget shall be made in accordance with Standard Provision of this Grant, entitled "Revision of Grant Budget."

Cost Element	From** to**		From** to**		Total*	
	\$U.S.	Local Currency	\$U.S.	Local Currency	\$U.S.	Local Currency
1.						
2.						
3.						
4. Training						
5. Procurement						
6. Indirect Costs overhead						
Total \$						

\* Use all three columns for incrementally funded grants, otherwise use only this column.

\*\* Insert effective and expiration dates of grant or obligation/funding dates.

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E. Reporting and Evaluation

(Describe both fiscal and technical reporting requirements and evaluation criteria and schedules. See paragraphs 1M, "Financial Reporting Requirements," and 1N, "Monitoring and Reporting Program Performance," of Handbook 13, Grants. Specify the address to which each report is to be delivered.)

F. Special Provision

(Use this paragraph to delete inapplicable Standard Provisions and add provisions of special applicability as authorized. Included should be waivers, including authorized local cost financing, and any alterations to the Standard Provisions which have been approved as deviations for the specific grant or grant program.)

G. Indirect Cost Rate

(Set forth the applicable indirect cost rate(s), base(s) on which they apply, and the Grantee's accounting period(s) they cover, as provided in the appropriate Standard Provision. If an Indirect Cost Rate Agreement has been executed by A.I.D. or a cognizant Federal agency, such rate(s) are required to be incorporated herein if such costs are covered by the grant.) The most current overhead information should be obtained from the Overhead and Special Costs and Contract Close-Out Branch (SER/OP/PS/OCC).

II. Title to Property

(Specify to whom title will vest for property, by category if appropriate.)

(For grants having a procurement element greater than \$250,000, add the following:)

I. Authorized Geographic Code

The authorized geographic code for procurement of goods and services under this grant is \_\_\_\_\_.

1987





(D) Accounting System	Yes	No	<u>Evidence Obtained by</u>
1. Cash Receipt Journal for AID Funds	_____	_____	_____
2. Cash Disbursement Journal AID Funds	_____	_____	_____
3. General Journal for AID Funds	_____	_____	_____
4. General Ledger for AID Funds	_____	_____	_____
5. Subsidiary Ledger for AID Funds	_____	_____	_____
6. Reconciliation of Journals, General Ledger and Subsidiary Ledger	_____	_____	_____
7. Separate Checking Account For Deposit and Disbursement of AID Funds	_____	_____	_____
8. Periodic Reconciliation of Bank Statement for AID Funds/ Account	_____	_____	_____
9. Accounting entries will refer to documentation which supports the entry and is filed in such a way that it can be easily located	_____	_____	_____
10. The system will enable an auditor to trace readily each accounting transaction from accounting reports to source documents to determine the validity of project expenditures	_____	_____	_____
11. Procedures to minimize the time elapsing between the transfer of funds from the U.S. Treasury and the disbursement by the project	_____	_____	_____

- General Comments and Recommendations

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(C) Reporting System:	Yes	No	Evidence Obtained by
1. Review of the Accounting Records by the Director Regularly	_____	_____	_____
2. Periodic Finance Reports	_____	_____	_____
3. The System generates accurate and current financial reporting information	_____	_____	_____
4. No reports show comparisons with budgets and past performance	_____	_____	_____
5. Are reports timely and accurate	_____	_____	_____
6. A systematic method to assure timely and appropriate resolution of audit findings and recommendations	_____	_____	_____
7. General Comments and Recommendations			

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(II)	Voucher Processing and Payment Verification System	<u>Yes</u>	<u>No</u>	<u>Evidence Obtained by</u>
	1. Vocher Log	_____	_____	_____
	2. Procedures for determining allowability and allocability of costs, and reasonableness	_____	_____	_____
	3. Procedures for approval for voucher payment	_____	_____	_____
	4. Verification of amount claimed on the voucher is accurate	_____	_____	_____
	5. Verification of amount claimed on the voucher against the commitment documents and/or authorization	_____	_____	_____
	6. The system must ensure that approved budgets/budget categories do not become over-subscribed; i.e. a system for identifying both commitments/encumbrances and funds due/receivables by budget categories	_____	_____	_____

7. General Comments and Recommendations

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ANNUAL REPORT

VOLUNTARY HEALTH SERVICES, MADRAS



# The Voluntary Health Services

ADYAR : : MADRAS - 600 113

ANNUAL REPORT

**-1989-90**

# THE VOLUNTARY HEALTH SERVICES

ADYAR, MADRAS-600 113

Registered under the Societies Registration Act (Central Act XXI of 1360)

OFFICE BEARERS FOR THE YEAR 1989—90  
(as on 31st March 1990)

President : SRI C. SUBRAMANIAM (upto 26-3-90)  
DR. N. MAHALINGAM (from 27-3-90)

## BOARD OF TRUSTEES

Sri C. Subramaniam  
Sri M.A. Chidambaram, *Managing Trustee*  
The Advocate General, *Government of Tamil Nadu*  
The Accountant General—I, *Tamil Nadu*  
Sri A.C. Muthiah  
Sri C.U. Shah  
Dr. B. Ramamurthi  
Sri N. Sugalchand Jain  
Smt. Shakuntala Balaraman

## MEMBERS OF THE CENTRAL COMMITTEE

Sri M.A. Chidambaram  
*The Advocate General, (TN)*  
Sri A.C. Muthiah  
Dr. Prathap C. Reddy  
Sri M.A.M. Sp. Vairavan  
*The Collector of Madras*  
*Chairman, Madras Chamber of*  
*Commerce & Industry*

Dr. P. Krishnan  
Dr. K.S. Sanjivi  
Dr. N.S. Murali (*Secretary*)  
Dr. T.K. Jacob  
Dr. P.B. Sadasivan  
Smt. Leela Sekar  
Sri M. Subramaniam (*Treasurer*)

Sri R. Ramakrishnan  
Dr. B. Ramamurthi  
Dr. Mrs. Indira Ramamurthi  
Dr. Ravi Ramamurthi  
Smt. Lakshmi Ramanathan  
Sri V. Narayanaswami  
Sri N. Srinivasan  
Smt. A. Kamala Achi  
Sri C.U. Shah  
Sri R.C. Parekh  
Sri V. Ramiah  
Sri S. Jayaraman  
Sri N. Sugalchand Jain  
Smt. Chandrabai Sugalchand Jain  
Sri L.L. Narayan  
Sri R. Rajagopal  
Dr. J. Balasubramaniam  
Sri R.S. Murti  
Sri P.R. Venkatachalam  
Sri R.T. Chari  
Dr. S. Sundaram  
Sri V.M. Jain

Ms. Maithreyi Ramadurai  
Dr. C.V. Krishnaswami  
Dr. Mrs. M. Amruthavalli  
Sri M.S. Krishnamoorthy  
Sri S. Atmaram Bhatt  
Sri A.R. Dharmaraja  
Sri T.V. Madhav  
Sri V. Prabhakar  
Smt. Thilakavathi Mohan  
Sri R. Ramaswamy  
Sri S.T. Vanchinathan  
Sri N.K. Vinayakam  
Sri P.R. Sundaravadivelu  
Dr. K. Venkateswara Rao  
Dr. N. Veeraraghavan  
Dr. B.S. Ramakrishnan  
Dr. V. Raju  
Dr. Mrs. Malathi Madhavan  
Dr. A. Ganesan  
Dr. K. Thomas Joseph  
Dr. S. Kameswaran  
Sri R. Srinivasan

# THE VOLUNTARY HEALTH SERVICES

ADYAR, MADRAS—600 113.

## ANNUAL REPORT FOR THE YEAR 1989—90

The Thirty-first Annual General Meeting was held on the 26th August 1989 at the Voluntary Health Services, Adyar, Madras 600 113. On the 31st March 1990, there were 540 Patrons and 272 Life Members. During the year under report the Central Committee met 4 times.

A list of donations received during the year is appended. The particulars of specific endowments and details of Reserves of the Society as on 31-3-1990 are also appended.

Consequent to Sri C. Subramaniam taking over as Governor of Maharashtra, he relinquished the Presidentship of the VHS with effect from 26-3-1990. We record with thanks our deep appreciation of the valuable contribution made by Sri C. Subramaniam to the VHS.

The Central Committee unanimously decided to invite Dr. N. Mahalingam, the well-known Industrialist to be the next President of the Society. Dr. N. Mahalingam kindly accepted our invitation and assumed Presidentship with effect from 27-3-90.

The year has been an eventful one in that the Voluntary Health Services celebrated its Silver Jubilee, on completing 25 years of dedicated service in providing Health Care to the underprivileged of society.

The Silver Jubilee function was held at Naradha Gana Sabha Hall, T.T.K. Salai, Madras 18 on the 16th April 1989 at 9-30 a.m. His Excellency Sri R. Venkataraman, President of India was kind enough to inaugurate the function. His Excellency Dr. P.C. Alexander, Governor of Tamil Nadu kindly presided over the function.

The Hon'ble Dr. R. Ponmudi, Minister for Health, Government of Tamil Nadu graciously unveiled the Foundation Stone for the Post-Partum Block, the grant for which was given by the Family Welfare Department of the Government of Tamilnadu under the World Bank Project. The Minister also released the Silver Jubilee Souvenir which was brought out to mark the occasion.

During the function, mementos were presented to the VHS staff who had completed 25 years of service. We are thankful to the Department of Family Welfare for their kind donation for the Post-Partum Block inclusive of Labour Ward, Operation Theatre and a Post-operative Block, the construction of which is presently in progress.

We are indeed grateful to late Sri Chakravarthi Iyengar and Smt. C. Jayammal for their valuable donation of Rs. 16,99,923 towards the construction of an Acute Care Centre, for the Stroke Research Project and an endowment for maintenance of beds in the Hospital. The cheque was presented at the function by the Executors of the WILL of the donor. The establishment of Acute Care Centre is in progress; plans have been sanctioned and work is scheduled to start soon.

As part of the Silver Jubilee celebrations another function was also organised at the VHS campus on 30-4-1989 when suitable mementoes were distributed to all the remaining staff of VHS followed by Dinner.

The extension of Nephrology Block with seven special rooms, a General Ward and an Intensive Care Ward was completed and it started functioning from 14-7-89. This was made possible by the munificent donation of Sri Marudhar Kesari Jain Seva Sangh. We were honoured to have the presence of His Holiness Poojya Pravarthak Roopchandji Maharaj and His Holiness Poojya Up Pravarthak Suganmunji Maharaj for the commissioning of the Nephrology Extension Block. This block is fully functional now.

The Ramabhadran Diabetes Research Laboratory was inaugurated on the 2nd September 1989 by the Hon'ble Dr. Ponmudi, Minister for Public Health and Family Welfare, Government of Tamil Nadu. A book named "The Diabetes Food Fiesta" was released and food-fair organised during the function.

We are grateful to the TAG Corporation and their group of companies whose munificent cash donation was solely instrumental for the construction of Ramabhadran Diabetes Research Laboratory.

The Neurosurgery extension block with one more Operation Theatre and a Ten-bedded ward is under construction and is nearing completion. We are thankful to the various donors for their generous help.

The proposal for setting up a Diagnostic Centre under Ramamurthi Neurological Research Foundation (RNRF) within VHS campus with hightech facilities such as N.M.R. has been approved and will be implemented in due course.

A research project under the Department of Biotechnology, Government of India is being established at the VHS under Prof. P.V. Sundaram on Protein Engineering and Biomedical Research. Action is in progress.

The existing rented accommodation of the Diagnostic Centre Mylapore has to be surrendered shortly. Purchase of a ground floor flat in North Mada Street, Mylapore, with a plinth area of 920 sq. ft. has been completed. The building will be ready shortly for shifting the Diagnostic Centre.

The Project for Eradication of Leprosy and Tuberculosis by Primary Health Care Delivery through Mini Health Centres run with the assistance of Government of India is functioning on a full scale. The referral cases are treated at the main Centre.

The two Blocks—one for the out-patients and the other for the in-patients constructed under the Project at a cost of Rs. 25 lakhs were occupied during the year.

Prof. K.S. Sanjivi Endowment Lecture (third in the annual series) was delivered by Dr. Harcharan Singh, Adviser (Health), Planning Commission, Government of India on the 20th January 1990.

The VHS in collaboration with the Rotary Club of Madras South, opened a new Clinical Laboratory at 65, III Main Road, Gandhi Nagar, Madras-600 020. The Laboratory was inaugurated by Rtn. R. Ramamurthy, President, Rotary Club of Madras South, on the 21st February 1990.

We are thankful to the Rotary Club of Madras South for providing the accommodation and necessary equipment to run the Laboratory. The above clinical Laboratory is fully equipped and staffed to take up routine tests in Clinical Pathology, Biochemistry, Blood Banking, Microbiology and Histopathology.

We are grateful to the British Deputy High Commission, Madras for their donation of reference Books in all specialities to the tune of £2500.00 under the Overseas Development Administration Books Presentation Programme.

We are grateful to M/s. Aiyar & Co. for auditing the accounts for the year 1989—90.

We are also grateful to the Government of India, Government of Tamil Nadu, several individual donors, Patrons and members of the Medical Profession for their interest and support financially and otherwise to us.

#### Hospital Helpers :

We are grateful to the Hospital Helpers Trust for their efforts in maintaining the Linen for the Hospital. A sale has been conducted by them the proceeds of which has been utilised for the purchase of linen for the Hospital. We are also thankful to the other Hospital Helpers who help us in the running of various departments.

The reports on various projects for the year are attached as annexures.

### REPORTS ON PROJECTS

#### 1. Medical Aid Plan :

The number of subscribers (families) to the Medical Aid Plan with distribution according to the income groups is as follows :

As on March 31, 1990

Free group	(Rs. below Rs. 300/-p.m.	2883
P III	(Rs. 301 to 750/- p.m.	147
P II	(Rs. 751 to 1500/- p.m.	11
P I	(Rs. 1501 to 3000/- p.m.	Nil

Under individual subscriber scheme the distribution is as follows :

Group	Income	Total subscribers
CAT I	Rs. 0 — 300/- p.m.	2268
CAT I-A	Rs. 301 to 500/- p.m.	2580
CAT II	Rs. 501 to 750/- p.m.	504
CAT III	Rs. 751 to 1500/- p.m.	673
CAT IV	Rs. 1500 to 3000/- p.m.	400
CAT V	above Rs. 3000/-	177

#### 2. Students Health Programme :

Students from various schools medically examined and advised.	11800
Master Health Check-ups	40
Miscellaneous Medical Check-ups	286

#### 3. Food Handlers Scheme :

Total No. of Food Handlers treated during the year :	980
--	-----

#### 4. Madras Race Club Hospital :

a) Total number of outpatients treated during the year	43,135
b) Daily average	118
<i>Details of inpatients treated :</i>	
a) Total No. of inpatients treated during the year	6691
b) Daily average	181

#### Speciality-wise details :

General Surgery	784	Psychiatry	105
General Medicine	1820	Ophthalmology	239
Urology	40	Neurology	318
Orthopaedics	351	Neurosurgery	630
Gynaecology	159	E.N.T.	141
Geriatric	7	Skin & Allergy	44
Chest Diseases	135	Cardiology	152
Plastic Surgery	6	Dental	2
Diabetes	513	Nephrology	167
Paediatrics	679		

#### c) Department of Gynaecology :

Total No. of out-patients treated	4500
Minor surgeries	193
Major surgeries	40

<i>d) Department of General Surgery :</i>	
Total No. of out-patients	7454
Total No. of inpatients treated	784
Major Surgery	582
Minor surgery	202
Outpatient Procedures	1462
<i>c) Department of Orthopaedics :</i>	
No. of out-patients treated	3814
No. of Surgery (including minor surgeries)	250
<i>f) Department of Urology :</i>	
Total No. of out-patients treated	350
No. of surgery	103
<i>g) Physiotherapy :</i>	
Total No. of out-patients	4404
Total No. of in-patients	762
<i>h) E.N.T. Department &amp; Venki's Department of Audiology &amp; Speech Therapy</i>	
New cases	1214
Old cases	1919
Total No. of patients treated	3133
Total No. of Audiograms	348
Total No. of inpatients treated	141
Total No. of operations	141
No. of Steapedectomy operations	30
No. of Neuro-autology cases	30
Total No. of Speech Therapy	42
<i>i) Ophthalmic Department :</i>	
Total No. of out-patients treated	4107
Total No. of inpatients treated	239
No. of operations performed	239
<i>j) Nephrology Unit :</i>	
Total No. of Haemodialysis	872
Total No. of inpatients	167
Renal Biopsy	8
Sub-clavion Catheterization	4
Total No. of Kidney Transplantations	47

<i>k) Intensive Care Unit :</i>	
Total No. of patients treated	487
<i>l) Intensive Cardiac Care Unit :</i>	
Total No. of patients treated	140
No. Monitored	67
<i>m) Neurology Department :</i>	
No. of out-patients treated	2147
No. of in-patients treated	318
<i>n) Department of Neurosurgery :</i>	
Total No. of out-patients	739
Total No. of in-patients	630
Total No. of Operations done	343
<b>5. Diagnostic Centre :</b>	
Clinical Pathology	59,754
Biochemistry	26,228
Bacteriology	5,148
Histopathology	2,042
<b>6. Blood Transfusion Service :</b>	
An intensive drive for building up the stock of the Blood Bank at our Centre was organised.	
We are thankful to the donors and organisers of various institutions who participated in the Blood Collection Camps.	
Total No. of camps during the year is	17
<i>A resume of work done in the Department is furnished below :</i>	
Rh Typing & Blood Grouping	2947
Rh Antibody tests Direct-9      Indirect-440	449
Coombs Test	450
Cross-matching tests	2098
Blood Transfusions	866
Blood donors—all voluntary	866

<b>7. X-Ray Department :</b>	
Chest X-rays—70 mm	3167
Large	5558
Other X-rays (Ba. meal, IVP, Neuro-Radiological investigations, Angiograms, Myelograms, etc.)	6879
Electrocardiograms	3393
<b>8. Diabetes Department :</b>	
Total No. of out-patients treated	2572
in-patients	513
<b>9: Day Care Centre :</b>	
Psychiatric cases	3300
Medical cases	205
Surgical cases	105
Nephrology cases	129
<i>Endoscopy</i>	
Gastroscopy	375
Nasopharyngoscopy	16
Colonoscopy	2
	—
	393
	—
Total No. of patients treated during the year:	4132
<b>10. Leprosy Unit :</b>	
Total No. of cases treated	553
L.R.D.	68
Inactive	80
Regular	55
Irregular	350
We are thankful to the Govt. of Tamil Nadu for the supply of free drugs.	
<b>11. Tuberculosis :</b>	
Old cases	141
New cases	454
Total No. of Mantoux Tests done	1292

We are thankful to the Government of India for the supply of Anti-TB drugs free of cost and to the State Social Welfare Board for their grant to meet part of the expenditure of supply of special drugs, nutritive diet, etc.

**12. Family Welfare Unit :**

The Urban Family Welfare Planning Centre aided by the Government of Tamil Nadu is working satisfactorily. The out-turn of work done by the Centre is furnished below :

No. of Vasectomies done	21
No. of Tubectomies done	702
No. of I.U.D.	123
Oral Pills distributed	pkts 82
Regular users of Nirodh	82

**13. Teaching Programme :**

(a) *M.N.A.M.S. Training :*

VHS is recognised for Diploma in National Board of Examinations for the following subjects :

- |                     |                                   |
|---------------------|-----------------------------------|
| 1. General Medicine | 4. Family Medicine                |
| 2. General Surgery  | 5. Social and Preventive Medicine |
| 3. Neurosurgery     |                                   |

(b) *College of Medical Technology :*

Eighteen students were admitted to the 27th Batch of the Diploma course in Medical Laboratory Technology for the year 1989—90. At the examination held in August 1989, 15 students of the previous batch qualified for the Diploma.

Three students were admitted to the Health and Hospital Administration course during the year 1989—90. In the examination held in August 1989, 4 students of the previous batch qualified for the Diploma.

Ten students were admitted to the Diploma course in Nutrition and Dietetics during the year 1989—90. In the Examination held in August 1989, 8 students of the previous batch qualified for the Diploma.

We are thankful to the following institutions for their spontaneous co-operation for the above training programme :

Directorate of Public Health; Institute of Venereology, Madras Medical College, Madras; Corporation of Madras; Institute of Child Health and Hospital for Children, Egmore; Govt. King Institute, Guindy; Tuberculosis Research Centre, Cherput; Christian Medical College and Hospital, Vellore. Schefflin Leprosy Research & Training Centre (SLR & TC) Sanatorium, Karigiri; and Poonamallee Health Unit, etc.

Our thanks are also due to the guest lecturers who took great interest in training the students. Our thanks also go to external examiners who were kind enough to be examiners for the above Diploma courses.

## DEPARTMENT OF COMMUNITY HEALTH :

The Department of Community Health undertakes the following training programmes :

### 1. Multipurpose Health Worker (Female) Course :

During the year 49 students were admitted for the 1st Semester. In July 1989, 39 candidates appeared for the 1st Semester examination.

### 2. Six months Ad hoc Multipurpose Health Workers Course :

The last batch of 53 candidates had completed their course during the month of June 1989.

### 3. Multipurpose Health Workers (Male) Course—One year duration :

22 candidates have been admitted for the newly started one year MPH (male) course in August 1989.

### 4. Lay First Aiders' Course :

18 candidates from Urban Medicare Centre, Kottur and Sri Ayyappa Charitable Trust have completed their one month training in August 1989.

### 5. 3½ years Course in Nursing (Diploma in Nursing)

10 ANM candidates are undergoing this training after completion of their training in August 1989.

The Department gives orientation training to Medical Officers and Paramedical personnel from other voluntary organisations in Community Health.

### VHS Bulletin :

20th & 21st Issues of the Bulletin were released during the year (July 89 and February 90).

## RESEARCH PROGRAMME OF VARIOUS DEPARTMENTS :

### a) Community Health—MAC Institute of Community Health

The following studies were conducted during the year.

1. Sociological study of the common practices during pregnancy "Labour and Puerperium in the rural areas."
2. Sociological study of knowledge, attitudes and behaviour of TB & Leprosy patients.
3. Congenital malformation in children born out of marriage of close relatives.
4. A study of vital rates among 35,000 rural population in five mini health centre areas in Chengai-Anna District.

5. A study of prevalence of Anaemia in pregnancy in the rural community.
6. A survey of abnormal "Pap" smear and risk factors associated with Cancer Cervix in married women above 25 years of age.

## LEPROSY RESEARCH UNIT—Cultivation of M. Leprae :

Employing the well characterised strain of M. Leprae, currently being used for the production of leprosy vaccine by the WHO in its IMMLEP programme, the studies on the cultivation of M. Leprae are being continued. Based on these studies, it has been possible to delete 40 compounds from the original medium V and develop a modified medium V (L1)

### Treatment of Leprosy :

Since 1983, a long term study has been in progress to compare the efficacy of the current multi-drug therapy with a regimen comprising of dapsons, theophylline, phenacetin maleate and terbutaline.

The findings would suggest that the conversion of bacterial index negativity is faster among patients receiving dapsons, theophylline, terbutaline and phenacetin maleate compared with those receiving dapsons, rifampin and clofazimine.

### Search for new Drugs :

Using the armadillo strain of M. leprae several compounds are being tested to determine their inhibitory properties in culture *in vitro*.

### Tuberculosis :

The liquid medium V(T) described earlier is chemically defined. It promotes large enough growth within 48 hours, which could be used for the isolation of the organism from minute inocula, its identification and for establishing its drug susceptibility. There is a 2 to 6 fold multiplication within 48 hours after which it falls.

### Neurology :

1. An *on-going* study of stroke (prospective) with particular reference to alcohol as a risk factor is under way.
2. An ongoing study of epilepsy 50 years and above of the first 75 cases submitted to the National Medical Journal of India.

### Diabetes Research :

A Diabetic camp was conducted where 108 persons from the Police Department were screened at Besant Nagar Police Station. 3 new Diabetics were detected.

The continuing Medical Education Programme was organised in the VHS on 2nd September 1989. For this Scientific Programme, eminent diabetologists and other specialists spoke on the occasion on different topics of great interest in diabetes.

Genetic research of the Juvenile Diabetes has been started along with other on-going projects.

#### Department of General Surgery :

1. Study of the incidence of convebacterim Pyloric Duodeni Infection in Scuth India.
2. Study of Anaerobic infection in Diabetic foot and management of Diabetic foot infection by Decompression procedure.

#### Department of Neurosurgery :

1. Recurrence of Pain after Laminectomy.
2. Recovery of function in spinal cord compression after surgery
3. Prognostic factors in Glioma therapy
4. Immuno-histology of Pituitary tumours.
5. Shunt failure
6. Epilepsy and constitution
7. Pre- & Post-operative epilepsy in Meningiomas
8. Pre-operative autonomic disturbances in posterior fossa tumours
9. Return of visual functions after pituitary surgery
10. Delayed onset of facial palsy after ANF surgery
11. Failure of medical treatment of tuberculosis—immunological/pharmacological.

#### Indian Medicine :

1. The antimalarial effect of Ayush 64 in P. vivex malarial cases is being assessed at the OP and IP level. During the review period, 5 cases have been studied.

The anxiolytic effect of Ayushman—15 in acute anxiety case is studied, with the co-operation of the Psychiatry Department of V.H.S. During the review period 6 cases have been included of whom 4 completed the treatment period.

The trial with Bimbi and Nishamalaki in Diabetes Mellitus cases is being continued. During the review period, 22 cases were screened for Diabetes but of these only 3 were found fit for inclusion in the trial.

The Rasayana effect of a compound preparation ABSTEG containing 6 drugs is assessed in apparently healthy males in the age group of 45—55 years. So far, 35 volunteers were included in the trial, of whom 20 volunteers completed the treatment period of 6 months.

An Ayurvedic OP Department was started in VHS Hospital on 15-4-89 So far 241 new and 365 repeated cases have been treated.

Ayush AC-4 an oral contraceptive is being tried in married women of child-bearing age. During this review period 23 cases are actively taking part.

The work of editing the monograph on "A comprehensive Plan on the Role of Ayurveda in Maternity and Child Health" was entrusted to the Centre. The original draft was redrafted incorporating appropriate tables, charts and drawings based on the material collected from different sources and submitted to the Council.

#### Physiology :

During the year under report, the following two research projects were continued :

1. Under the Ministry of Defence : "Effects of variable or pulsating magnetic field on human systems".
2. Under the Ministry of Environment and Forests : "Interaction of Electro-magnetic fields with the biosphere with special reference to effects on living systems.

LIST OF DONATIONS RECEIVED 1989-90 :

M/s. Venkatesa Agencies	sR. 1,00,000 00
Estate of Late C. Jayammal	94,921 87
Sri Marudhai Kesari Jain Seva Sangh	63,000 00
The Clinic	50,000 00
Dr. (Smt) Indira Ramamurthi	40,000 00
Sriram Fibres Ltd.	30,000 00
East India Pharmaceutical Works	30,000 00
Mr. D. Veluswamy	33,000 00
C.L. Baid Mehta College of Pharmacy	25,000 00
Indian Cultural Research Trust	25,000 00
Indo Metal Co.	20,000 00
Mr. T.N. Krishnaswamy	20,000 00
Elder Pharmaceuticals	20,000 00
Dollar Co India Pvt. Ltd.	15,000 00
Karishma Leather Works	15,000 00
Mr. V.S. Dhandapani	10,000 00
Mr. S. Radhakrishna	10,000 00
Mr. P.A. Narasimha Raja	10,000 00
A.S. Drilling unit	10,000 00
T.S. Rajam Charities	10,000 00
Sundaram Finance Ltd.	10,000 00
Kappa Consolidated P. Ltd.	10,000 00
Ch. Lok Kumar	10,000 00
Ch. Ram Mohan Rao	10,000 00
Mrs. E. Bala	8,000 00
Mr. S. Guhan	6,000 00
Rajam Pankajam Trust	5,500 00
Alamelu Trust	5,000 00

Dr. Neysen	5,000 00
Dr. A. Ramachandran	5,000 00
Mr. R. Srinivasan	5,000 00
Mr. V. Selvadurai	5,000 00
R. Ramaswamy Chettiar Trust	5,000 00
Mrs. Janaki Narayanan	5,000 00
Mrs. Sakunthala Loyalka	5,000 00
Padma Sugavanam Trust	5,000 00
Sister Zeema	5,000 00
Sri P.S. Loyalka	5,000 00
Dr. S. Narayanan	5,000 00
Mr. M. Subramanian	4,000 00
Ucal Pvt. Ltd.	4,000 00
Mr. M.S. Govindan	4,000 00
Mr. N.G. Swamy	3,101 00
Ashok Tobacco Co.	3,000 00
Lt. Gen. R. Narasimhan	3,000 00
Dr. K.R. Seetharaman	3,000 00
Mr. M.S. Krishnamurthy	3,000 00
Mr. V. Venkataraman	2,531 00
FOVHA	2,500 00
C.P.C. Pharmaceutical	2,500 00
Bangalore Pharmaceutical & Research Laboratories	2,100 00
Vesture India Ltd	2,001 00
Anil Tolasaria	2,000 00
S. Swaminathan	2,000 00
Janata Textiles	2,000 00
Jayalakshmi Viswanathan	2,000 00
N. Kannan	2,000 00
Dr. K. Mathangi Ramakrishnan	2,000 00

N. Rajagopalan Charitable Trust	Rs. 2,000 00
Indupur Lakshmana & Sons	2,000 00
Mr. N.R. Iyer	2,000 00
Mr. M.S. Ramanujam	2,000 00
Mr. Francis Riges	2,000 00
Mr. R. Parikshit	2,000 00
Ms. Alamu Nachiar	2,000 00
Ranga Corporation	2,000 00
Mr. C.V.R. Panickar	2,000 00
Mr. K.N. Prabhakaran	2,000 00
Dr. S. Vijayakumar	2,000 00
Mr. Srimathi Busch	2,000 00
K.N. Parasuraman	2,000 00
Smt. Shantha Guhan	2,000 00
Mr. A. Kuppurajan	2,000 00
Ms. V. Ranganayaki	2,000 00
Mahalingam & Rebello	2,000 00
Y B R Services	2,000 00
Unicorn Bangalore Pvt. Ltd.	2,000 00
Yadugiri Ammal Alamelu Ammal Trust	2,000 00
Janata Industries	1,750 00
J Cot Industries	1,750 00
Limenaph Chemicals	1,500 00
Mr. Sanjit Roy	1,500 00
Dr. J. Indira	1,500 00
Mr. S. Krishnamurthy	1,500 00
Mr. Prakashmull	1,500 00
Kanakammal Seethapathy Charitable Trust	1,200 00
Ms. Shantha Ramachandran	1,200 00
Calcutta Canvas Co.	1,100 00

Vinod Jain	Rs. 1,100 00
Mr. N. Sethuraman	1,011 00
Ms. Veena Jaipura	1,011 00
Mr. R. Sundararaman	1,001 00
Mr. J. Pydah	1,000 00
Mr. J. Chandrasekaran	1,000 00
Bhishma Reddy	1,000 00
Ms. Gracy Verghese	1,000 00
Ms. Jyoti Chaulaji	1,000 00
Mr. V.R. Nair	1,000 00
Smt. Lakshmi Kumari	1,000 00
Torent Pharmaceuticals Ltd.	1,000 00
Mr. R. Soora Nagamaiah Chetty	1,000 00
R.K. Daga	1,000 00
Capt. Pydah	1,000 00
Baliga Lighting Equipments Co.	1,000 00

PARTICULARS OF SPECIFIC ENDOWMENTS as on 31st March 1990

A. FUNDS

<b>For Maintenance of M.R.C. Hospital :</b>	
Raffle Fund	Rs. 1,58,453 00
Endowment Fund	15,57,593 70
M/s. Thirugnanam & Co. Endowment Fund	50,000 00
Ranganayaki Memorial Fund	1,00,023 17
Poor Feeding Fund	5,27,407 20
V.R. Sundaram Retina Fund	50,000 00
Seshadri Renal Fund	5,000 00
Jaya Parikshit Geriatric Fund	5,000 00
Venki Audio Therapy Fund	2,00,000 00
Nepirology Fund	6,00,000 00
<b>For Dr. Achanta Lakshmi pathi Neurosurgical Fund :</b>	
Arogya Ashrama Smithi	2,00,000 00
<b>For K. Gopalakrishna Department of Neurology :</b>	
Carburettors Ltd.	50,000 00
Srihari Charitable Trust	25,000 00
Dalmia Cements (Bharat) Ltd.	10,000 00
Mrs. Radhamani Fund (By Mr. R. Sundararaman)	5,000 00
General Fund	5,000 00
Estate of Late C. Jayammal	2,00,000 00
<b>For Medical Aid Plan :</b>	
C.U. Shah Charities	5,00,000 00
Larsen & Toubro Day Care Fund	4,00,000 00
<b>For Diagnostic Centre :</b>	
Mrs. Jadavbai Nathmal Singhvi Fund (By M/s. Sugal Lottery Agency)	5,00,000 00
<b>For Blood Bank :</b>	
Arvind Laboratories	6,00,000 00
Estate of Dr. K.S. Ranganathan, etc.	25,000 00

<b>For Leprosy Research :</b>	
Sri M.S. Krishnamurthy & his sons	Rs. 1,00,000 00
Lions Club of Madras (Host Club)	25,000 00
Mrs. Savithri Rajan	10,000 00
Sri K. Krishnaswami	5,000 00
<b>For Community Health Projects :</b>	
General Fund	4,10,000 00
C.M. Maichael Fund	11,150 00
J.C. Kumarappa Memorial Fund	33,000 00
<b>For Educational Purpose :</b>	
Dr. Rangachari Fund	1,00,000 00
Prof. K.B. Madhava Fund	55,000 00
Dr. K.S. Ranganathan GMT Prize Fund	1,000 00
<b>For Diabetes Project :</b>	
Dr. D.V. Krishnamurthi	1,00,000 00
M/s. Dollar & Co. Pvt. Ltd.	39,001 00
Sri T.N. Krishnaswami	19,000 00
M/s. TAG Corporation	10,000 00
T.C. Trust	5,001 00
Dr. Mrs. Prema Krishnaswami (a) G.K. Subramaniam Fund	6,000 00
(b) Rao Sahib C.V. Krishnaswami Iyer Fund	5,000 00
Gowri Badran Fund	5,000 00
FACIT Asia Trust	5,000 00
Mrs. Janaki Narayanan	9,602 00
Others	91,396 00
General	
<b>Other Items :</b>	
J. Srinivasan Cardiac Research Fund	1,70,262 00
SABRA Fund	2,00,000 00
Chemotherapy Project Fund	35,000 00
S. Krishnamoorthy Ischemic Cardiac Fund	10,100 00
B. Jagannathadas Endowment Fund	30,000 00
Smt. Alamelu Garden Fund	20,000 00

Dr. Subramanian Suresh Library Fund	Rs. 20,001 00
Dr. K.S. Sanjivi Endowment Fund	1,50,000 00
Varasidhi Vinayakar Temple Fund	22,500 00
Bank of Baroda Employees' Medical Relief Fund	15,00,000 00
Sir Vepa Ramesam Nutrition & Dietetics Fund	4,000 00
Capt. S. Javaram Fund	35,000 00

**General Reserve Fund :**

(a) Estate of Late C. Jayammal	Rs. 9,97,921 87
(b) Mahalingam Mariammal Manivizha Trust	2,50,000 00
(c) Sundaram Clayton Ltd.	5,00,000 00
(d) Southern Petrochemicals Ltd.	5,00,000 00
(e) Others	3,03,117 96
	<u>25,51,039 83</u>

**B. CAPITAL RESERVES**

Donations capitalised Reserve	1,60,20,897 18
<i>Reserve :</i> For Central Government Equipment Grant	6,74,265 00
For Grants from Tamil Nadu Government of Building Constn.	21,95,867 00
For Equipment	1,89,404 25
For Additional Compensation paid for land	42,347 75
For India Population Project V (Building Construction)	5,08,000 00
Geriatric Reserve	1,09,041 59
Maintenance Reserve	30,13,830 95
Neurosurgery Department Reserve	2,50,000 00

\*\*\* Funds in Section 'A' invested in Nationalised Banks and/or Central and State Government undertakings.

Reserve in Section 'B' covered by investment in land, buildings, equipment, etc.

*Chartered Accountants*

Telephone : 567632

Telegrams : HISAB

MADRAS-600 002

27th July 1990.

**AUDITORS' REPORT**

We have audited the annexed Balance Sheet of The Voluntary Health Services, Madras as at 31st March, 1990 together with the Income and Expenditure Account for the year ended on that date which are in agreement with the books of accounts maintained by the said Voluntary Health Services.

*NOTE :* The land and Building of the Net Book Value of Rs. 83,91,260/- as on 31st March 1990 as per Schedule "H" annexed to the Balance Sheet are charged to the Tamil Nadu Government for the several building grants received from them, amounting to Rs. 22,38,215/- as on 31st March 1990.

*Subject to the above Notes :*

We have obtained all the information and explanations which to the best of our knowledge and belief were necessary for the purposes of our audit :

In our opinion, proper books of account have been kept by the said Voluntary Health Services, so far as appears from our examination of those books.

In our opinion and to the best of our information and according to the explanations given to us, the said accounts give a true and fair view :

- in the case of the Balance Sheet of the state of affairs of the above named Institution as at 31st March 1990, and
- in the case of Income and Expenditure Account of the excess of Expenditure over Income of its accounting year ending 31st March 1990.

**V. NATARAJAN**  
*Proprietor*

**AIYAR & CO.**  
*Chartered Accounts  
& Honorary Auditors*

**THE VOLUNTARY HEALTH SERVICES**  
**BALANCE SHEET AS ON**

AS ON 31.3.1989	LIABILITIES	Schedule	AS ON 31.3.1990
	<b>RESERVES :</b>		
1,65,62,942	Capital Reserve		1,96,30,781
27,79,570	Other Reserves		33,72,873
		A	2,30,03,654
1,93,42,512			
1,11,17,700	ENDOWMENT RESERVE FUND	B	1,15,51,529
	<b>UNSECURED LOANS</b>	C	
29,314	DEPOSITS PAYABLE	D	26,741
41,857	OTHER LIABILITIES	E	42,979
5,33,110	SUNDRY CREDITORS	F	8,40,393
7,52,479	UNSPENT BALANCES in Project Accounts	G	6,04,039
			Rs. 3,60,69,335
<u>3,18,16,972</u>			

*Note :* Contingent Liability for Gratuity Premium Payable to Life Insurance Corporation of India Rs. 1,27,511/-

Annexure to our report of date

V. NATARAJAN  
Proprietor

N.S. MURALI  
Hony. Secretary

AIYAR & CO.,  
Chartered Accountants &  
Honorary Auditors

MADRAS DATED JULY 17, 1990

(REGISTERED), MADRAS—600 113

31st MARCH, 1990

AS ON 31.3.1989	ASSETS	Schedule	AS ON 31.3.1990
	<b>FIXED ASSETS</b>		
1,49,08,701	Gross Block	H	1,77,92,024
56,31,252	Less : Depreciation		66,86,048
			111,05,976
92,77,449			
1,00,44,749	INVESTMENTS	I	115,16,079
	<b>CURRENT ASSETS, LOANS &amp; ADVANCES, DEPOSITS</b>	J	
69,74,339	Current Assets		74,16,163
2,40,988	Loans, Advances and Deposits		2,48,233
			76,64,396
17,960	EXPENSES RECOVERABLE	K	97,386
5,08,226	ADVANCES RECOVERABLE	L	3,62,038
47,53,261	INCOME & EXPENDITURE ACCOUNT	M	53,23,460
			Rs. 3,60,69,335
<u>318,16,972</u>			

M. SUBRAMANIAM

Hony. Treasurer

N. MAHALINGAM

President

**THE VOLUNTARY HEALTH SERVICES**  
**SCHEDULE FORMING PART OF THE BALANCE**

(REGISTERED) MADRAS-600 113  
SHEET AS ON 31st MARCH, 1990

	<i>Figures as on 31.3.1989</i>	<i>Additions during the year</i>	<i>Figures as on 31-3.1990</i>
<b>SCHEDULE "A"</b>			
<i>CAPITAL RESERVE</i>			
Donations Capitalised	136,61,057.86	23,59,839.32	1,60,20,897.18
Equipment Grant from Government of India	4,74,265.00	2,00,000.00	6,74,265.00
<b>Grants from Tamilnadu Government :</b>			
For Building Constructions	21,95,867.00	...	21,95,867.00
Equipments	1,89,404.25	...	1,89,404.25
Additional Compensation for Land	42,347.75	...	42,347.75
From Indian Population Project for Building Construction		5,08,000.00	5,08,000.00
	<u>1,65,62,941.86</u>	<u>30,67,839.32</u>	<u>1,96,30,781.18</u>
<i>OTHER RESERVES :</i>			
Geriatric Dept. Reserve	1,09,041.59		1,09,041.59
Maintenance Reserve	26,70,528.04	3,43,302.91	30,13,830.95
Neurosurgery Dept. Reserve	...	2,50,000.00	2,50,000.00
	<u>27,79,569.63</u>	<u>5,93,302.91</u>	<u>33,72,872.54</u>
<b>SCHEDULE "B"</b>			
<i>ENDOWMENT RESERVE FUND :</i>			
Raffle Fund	1,58,453.00	...	1,58,453.00
Endowment Fund	15,87,593.70	...	15,87,593.70
Dr. A. Lakshmi pathi Neuro-Surgical Centre Fund	2,00,000.00	...	2,00,000.00
	<u>19,46,046.70</u>	<u>—</u>	<u>19,46,046.70</u>
C/o.			

	<i>Figures as on 31.3.1989</i>	<i>Additions during the year</i>	<i>Figures as on 31.3.1990</i>
SCHEDULE "B" (Contd.)	B.T. 19,46,046.70	...	19,46,046.70
<i>ENDOWMENT RESERVE FUND :</i>			
Poor Feeding Fund	4,77,396.20	50,011.00	5,27,407.20
Ranganayaki Memorial Trust Fund	1,00,023.17	...	1,00,023.17
V.R. Sundhram Retiree Fund	50,000.00	...	50,000.00
Aravind Laboratory Blood Bank Fund	5,00,000.00	1,00,000.00	6,00,000.00
Leprosy Research Fund	1,40,000.00	...	1,40,000.00
General Reserve Fund	23,92,617.46	1,58,421.87	25,51,039.33
B. Jagannadhadas Endowment Fund	30,000.00	...	30,000.00
Chemotherapy Project Fund	35,000.00	...	35,000.00
S. Krishnamurthy Ischemic Cardiac Fund	10,100.00	...	10,100.00
Mrs. Alamelu Sanyal Garden Fund	20,000.00	...	20,000.00
Dr. K.S. Ranganathan GMT Prize Fund	1,000.00	...	1,000.00
Dr. Rangachari Education Fund	1,00,000.00	...	1,00,000.00
Prof. K.B. Madhawa Education Fund	55,000.00	...	55,000.00
Community Health Project Fund	4,10,000.00	...	4,10,000.00
C.M. Maichaeli Fund	11,150.00	...	11,150.00
J.C. Kumarappa Memorial Fund	33,000.00	...	33,000.00
Stroke Project Fund	2,95,000.00	...	2,95,000.00
Diabetic Project Fund	2,43,604.00	56,396.00	3,00,000.00
J. Srinivasan Cardiac Research Fund	1,50,262.00	20,000.00	1,70,262.00
SABRA Fund	1,70,000.00	30,000.00	2,00,000.00
Dr. Subramaniam Suresh Library Fund	20,001.00	...	20,001.00
	<u>71,90,200.53</u>	<u>4,14,828.87</u>	<u>76,05,029.40</u>
C/o.			

THE VOLUNTARY HEALTH SERVICES

SCHEDULE FORMING PART OF THE BALANCE

Figures as on 31.3.1989	Additions during the year	Figures as on 31.3.1990
B/c. 71,90,200.53	4,14,828.87	36,05,029.40
Dr. K.S. Sanjivi Endowment Fund	1,35,000.00	15,000.00
Dr. K.S. Sanjivi Endowment Fund	1,50,000.00	1,50,000.00
Captn. S. Jayaram Endowment Fund	35,000.00	35,000.00
Sir Veppa Ramesam Nutrition and Dietics Fund	4,000.00	4,000.00
Seshadri Renal Fund	5,000.00	5,000.00
Jaya Parikshiti Geriatric Fund	5,000.00	5,000.00
Vengli Audition and Speech Therapy Fund	2,00,000.00	2,00,000.00
Nephrology Fund	6,00,000.00	6,00,000.00
G.U. Shah Medical Aid Plan	5,00,000.00	5,00,000.00
Larsen & Tubro Day Care Centre Fund	4,00,000.00	4,00,000.00
B/c. 90,74,200.53	4,29,828.87	95,04,029.40

V. NATARAJAN  
Proprietor  
AIVAR & CO.,  
Chartered Accountants  
Honorary Auditors

N.S. MURALI  
Hon'y Secretary  
MADRAS DATED JULY 17, 1990

(REGISTERED), MADRAS-600 113

SHEET AS ON 31st MARCH, 1990

Figures as on 31.3.1989	Additions during the year	Figures as on 31.3.1990
B/c. 90,74,200.53	4,29,828.87	95,04,029.40
Jadhav Nathmal Singhi Diagnostic Centre Fund	5,00,000.00	5,00,000.00
Dr. K.S. Rangarathan Blood Bank Fund	25,000.00	25,000.00
Bank of Baroda Employees' Medical Relief Fund	15,00,000.00	15,00,000.00
Sri Varasiddhi Vinayagar Temple Fund	18,500.00	4,000.00
22,500.00	...	15,00,000.00
1,11,17,700.53	4,33,828.87	1,15,51,529.40
UNSECURED LOANS :	Nil	Nil
SCHEDULE "C"	Nil	Nil
B/c. 90,74,200.53	4,29,828.87	95,04,029.40

M. SUBRAMANIAM  
Hon'y. Treasurer

N. MAHALINGAM  
President

**THE VOLUNTARY HEALTH SERVICES**  
**SCHEDULE FORMING PART OF THE BALANCE**

	<i>Figures as on 31.3.1989</i>	<i>Figures as on 31.3.1990</i>
<b>SCHEDULE "D"</b>		
<i>DEPOSITS PAYABLE :</i>		
Staff Security Deposits	22,413.58	19,741.43
GMT Caution Deposits	6,900.00	7,000.00
	29,313.58	26,741.43
<b>SCHEDULE "E"</b>		
<i>OTHER LIABILITIES</i>		
Professional Tax	4,340.00	4,340.00
Employees' Provident Fund	31,542.95	33,064.95
Deposit Linked Insurance Fund	...	...
Undisbursed Salaries	5,974.15	5,574.00
	41,857.10	42,978.95
<b>SCHEDULE "F"</b>		
<i>SUNDRY CREDITORS</i>		
<i>(Amount Payable)</i>		
M.A. Chidambaram Institute of Community Health	1,752.00	1,752.00
G. Suresh Babu	25.00	25.00
Usha Ananthanarayan	84.00	84.00
R. Indumathi	92.00	92.00
N. Rajagopalan	100.00	100.00
Tamilnadu Slum Clearance Board	60.00	60.00
A. Satyavani	290.20	290.20
	C/o. 2,403.20	2,403.20

(REGISTERED), MADRAS—600 113,  
SHEET AS ON 31st MARCH, 1990.

	<i>Figures as on 31.3.1989</i>	<i>Figures as on 31.3.1990</i>
<b>SCHEDULE "F" (Contd.)</b>		
B.I.	2,403.20	2,403.20
S. Kunjithapadam	53,333.44	13,509.05
Gilbert Antony	3,800.00	3,800.00
New Bharat Electric Works	3,353.56	
G. Manimegalai	...	50.00
P. Indumathi	...	49.00
C. Munuswamy	5,000.00	5,000.00
V. Prema	81.00	81.00
Modern Works	8,528.75	5,001.01
VDB Electricals	1,206.25	1,206.25
S.R. Construction	...	33,000.00
V.R. Nachimuthu	15,300.00	13,960.00
Cohedec	200.00	200.00
Collections a/c	77.00	77.00
<b>Sundry Creditors for :</b>		
Repairs	15,000.00	82,947.90
Drugs	12,500.92	25,220.86
Family Welfare Staff a/c	60.00	60.00
Advance Collections from Patients	3,01,13.39	6,46,577.36
Payment of Adhoc Allowance on account of VHS Silver Jubilee Celebration	1,05,353.50	...
Honorarium to Auditors	3,000.00	4,000.00
General Engineering works	2,500.00	3,250.00
	5,33,041.01	8,40,392.63

**THE VOLUNTARY HEALTH SERVICES**  
**SCHEDULE FORMING PART OF THE BALANCE**

	<i>Figures as on 31-3-1989</i>	<i>Figures as on 31-3-1990</i>
<b>SCHEDULE "G"</b>		
<i>UNSPENT BALANCES IN PROJECT ACCOUNTS</i>		
Stroke Project	38,678.13	47,002.97
Diabetic Project	43,775.28	14,023.85
Community Health Project	1,42,075.45	2,13,727.63
Sri Varadidhi Vinayagar Temple	5,084.95	695.48
I.C.M.R./PL 480 Research on Non-Volitional Biofeed Back Study on Higher Nervous Disorders	23,883.22	9,522.66
Arogya Ashrama Samiti	3,245.85	603.50
<b>Government of India :</b>		
Ministry of Defence	65,649.62	...
Ministry of Environment and Forests	1,18,702.94	...
Adult Education Project	2,394.95	2,394.95
Sir Vepa Ramesam Nutrition & Dietetics	1,188.00	1,628.00
Dr. Subramanian Suresh Library A/c	321.40	1,913.25
J. Srinivasan Cardiac Research A/c	11,349.11	10,336.93
SABRA Account	12,257.71	2,953.99
Guruswamy Naidu Medical Relief A/c	11,273.65	7,273.65
USAID Project	53,358.14	6,736.29
<b>C/o.</b>	<b>5,33,238.38</b>	<b>3,18,813.15</b>

V. NATARAJAN  
*Proprietor*

N.S. MURALI  
*Hony. Secretary*

AIYAR & CO.,  
*Chartered Accountants*  
*Honorary Auditors*

MADRAS DATED JULY 17, 1990

(REGISTERED). MADRAS—600 113  
SHEET AS ON 31st MARCH, 1990

	<i>Figures as on 31.3.1989</i>	<i>Figures as on 31.3.1990</i>
<b>SCHEDULE "G" (Contd)</b>	<b>B.T. 5,33,238.38</b>	<b>3,18,813.15</b>
Temporary Advance by Tamilnadu Government for F.P. Operations	50,000.00	50,000.00
Kottur Urban Medicare Centre	1,360.77	6,797.11
Urban Health Posts	4,268.20	...
Bank of Baroda Medical Relief A/c	5,420.34	2,542.24
M.A. Chidambaram Record Fee A/c	4,986.00	4,986.00
Cohedee	5,502.00	6,702.00
Dr. K.S. Sanjivi Endowment A/c	11,010.70	3,351.97
Capt. S. Jayaram Endowment A/c	3,803.98	8,464.23
Teaching Programme	46,706.81	60,112.76
IPP-V Multipurpose Health Workers Training	...	80,700.00
VHS Bulletin	...	1,983.75
VHS Silver Jubilee Celebration A/c	71,725.80	24,126.56
Indian Cultural Research Trust A/c	0.92	0.92
C.S.I.R. A/c	74.94	74.94
Royal Commonwealth Society-Xerophthalmic Project	57.36	57.36
Cliquinol Project	...	21,003.00
Dr. A. Lakshmiipathi Memorial Health Posts	14,322.94	14,322.94
	<b>7,52,479.14</b>	<b>6,04,038.93</b>

M. SUBRAMANIAM  
*Hony. Treasurer*

N. MAHALINGAM  
*President*

SCHEDULE "II"

THE VOLUNTARY HEALTH SERVICES  
SCHEDULE OF FIXED ASSETS FORMING PART OF

Name of the Fixed Assets	GROSS BLOCK				
	Cost upto 31.3.1989	Additions during the year	Total	Sales* Deduction etc.	Cost upto 31.3.1990
Land	3,88,685	...	3,88,685	...	3,88,685
Buildings	92,63,762	16,60,809	1,09,24,571	...	1,09,24,571
Equipments	47,85,619	12,26,345	60,11,964	64,654	59,47,310
Furniture	4,53,837	63,852	5,17,689	6,410	5,11,279
Kitchen Utensils	16,798	3,380	20,178	...	20,178
	<u>1,49,08,701</u>	<u>29,54,386</u>	<u>1,78,63,087</u>	<u>71,064</u>	<u>1,77,92,023</u>

\*Items condemned and written off during the year.

V. NATARAJAN  
Proprietor

N.S. MURALI  
Hony. Secretary

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MADRAS DATED JULY 17, 1990

(REGISTERED), MADRAS-600 113

THE BALANCE SHEET AS ON 31st MARCH 1990

Upto 31.3.1989	Deduction* etc.	DEPRECIATION		NET BLOCK	
		For the Current year	To 31.3.1990	As on 31.3.1990	As on 31.3.1989
...	...	...	...	3,88,685	3,88,685
25,00,808	...	4,21,188	29,21,996	80,02,575	67,62,954
28,53,822	27,381	6,24,174	34,50,615	24,96,695	19,31,797
2,65,993	2,221	37,126	3,00,898	2,10,381	1,87,844
10,629	...	1,910	12,539	7,639	6,169
<u>56,31,252</u>	<u>29,602</u>	<u>10,84,398</u>	<u>66,86,048</u>	<u>1,11,05,975</u>	<u>92,77,449</u>

M. SUBRAMANIAM  
Hony. Treasurer

N. MAHALINGAM  
President

**THE VOLUNTARY HEALTH SERVICE**  
**SCHEDULE FORMING PART OF THE BALANCE**

	<i>Figures as on</i> 31.3.1989	<i>Figures as on</i> 31.3.1990
<b>SCHEDULE "I"</b>		
Shares in TUCS Ltd	50	50.00
<b>INVESTMENT IN FIXED DEPOSITS :</b>		
Endowment Reserve Fund :		
Investment in Fixed Deposits with		
Nationalised/Scheduled Banks	47,80,699	49,84,029.40
In State/Central Government Undertakings	52,63,000	65,31,000.00
Others : Unit Trust of India	1,000	1,000.00
	<u>100,44,749</u>	<u>115,16,079.40</u>
<b>SCHEDULE "J"</b>		
<b>CURRENT ASSETS, LOANS &amp; ADVANCES, DEPOSITS :</b>		
<b>a. Current Assets :</b>		
Cash on Hand including Imprest Cash	55,728.55	37,411.50
Cash in Savings Bank and Current Accounts	25,16,642.14	9,84,471.55
<b>Fixed Deposits :</b>		
Nationalised/Scheduled Banks	13,19,262.65	33,55,175.10
Public Sector Undertakings	30,00,000.00	30,25,000.00
Stock of Drugs Valued at Cost	82,706.12	14,105.03
<b>C/o.</b>	<u>69,74,339.46</u>	<u>74,16,163.18</u>

REGISTERED), MADRAS—600 113  
SHEET AS ON 31st MARCH, 1990

	<i>Figures as on</i> 31.3.1989	<i>Figures as on</i> 31.3.1990
<b>SCHEDULE "J" (Contd.)</b>	B.T. 69,74,339.46	74,16,163.18
<b>b. i) Loans and Advances :</b>		
Rent Advance	2,700.00	2,700.00
Festival Advance to staff	58,965.00	74,375.00
Compensation paid for F.P. Operations	92,315.00	73,091.00
Incometax Deducted at Source	1,783.00	1,822.00
	<u>1,55,763.00</u>	<u>1,51,988.00</u>
<b>ii) Deposits :</b>		
Indian Oxygen Ltd.	3,900.00	3,900.00
Reliance Agencies	3,250.00	3,250.00
TUCS Ltd.	1,800.00	1,800.00
Trilok Gas Service	190.00	6,190.00
Indian Oil Corporation	2,800.00	2,800.00
Ambu & Co..	150.00	150.00
Pest Control of India Ltd.	4,000.00	4,000.00
South India Carbonic Gas Co Ltd.	...	1,300.00
Corporation of Madras	200.00	200.00
Madras Electricity System	68,935.00	72,655.00
	<u>85,225.00</u>	<u>96,245.00</u>
<b>Total (a) + (b) (i) &amp; (ii)</b>	<u>72,15,327.46</u>	<u>76,64,396.18</u>

**THE VOLUNTARY HEALTH SERVICES**  
**SCHEDULE FORMING PART OF THE BALANCE**

	<i>Figures as on</i> 31.3.1989	<i>Figures as on</i> 31.3.1990
<b>SCHEDULE "K"</b>		
<i>EXPENSES RECOVERABLE</i>		
Urban Family Welfare Centre	17,238.25	66,025.30
Urban Health Posts	...	14,026.53
V.H.S. Bulletin Account	721.93	...
Adi Dravida Tribal Welfare Nursing Assistants Training	...	4,995.00
Ministry of Forest & Environment Research Project	...	12,338.76
	17,960.18	97,385.59
<b>SCHEDULE "L"</b>		
<i>ADVANCES RECOVERABLE</i>		
Urban Land Tax	2,556.50	2,556.50
Tamilnadu Cements Corporation	2,584.00	2,584.00
Permanent Advances for Purchases	50.00	50.00
R. Mari	3,000.00	2,400.00
Lay Secretary	1,721.45	2,013.45
N. Kaveriraju	4,250.00	1,500.00
	C/o. 14,161.95	11,103.95

V. NATARAJAN  
*Proprietor*

N.S. MURALI  
*Hony. Secretary*

AIYAR & CO.,  
*Chartered Accountants*  
*Hony. Auditors*

MADRAS DATED JULY 17, 1990

(REGISTERED), MADRAS—600 113  
SHEET AS ON 31st MARCH, 1990

	<i>Figures as on</i> 31.3.1989	<i>Figures as on</i> 31.3.1990
<b>SCHEDULE "L" (Contd.)</b>		
	B.f/ 14,161.95	11,103.95
Medical Equipment Services	200.00	16,800.00
Decan Talisman	750.00	750.00
Hyderabad Allwyn Ltd.	10,264.00	10,264.00
USAID Project	4,82,850.00	15,000.00
Yarco Sales Pvt. Ltd.	...	1,46,520.00
Srinivasa Real Estate	...	1,00,000.00
Bee Pee Instruments	...	1,600.00
Tec Co Constructions	...	60,000.00
	5,08,225.95	3,62,037.95
<b>SCHEDULE "M"</b>		
<i>INCOME AND EXPENDITURE ACCOUNT</i>		
Excess of Expenditure over income	47,53,260.89	
Add: for 1989—90	5,70,199.49	
		53,23,460.38
		53,23,460.38

M. SUBRAMANIAM  
*Hony. Treasurer*

N. MAHALINGAM  
*President*

**THE VOLUNTARY HEALTH SERVICES**  
**INCOME AND EXPENDITURE ACCOUNT FOR**

<i>As on</i> 31.3.89	<i>EXPENDITURE</i>	<i>As on</i> 31.3.90
	To Opening Stock of Drugs as on	82,706.12
71 137	1st April, 1989 (Valued at cost)	
22 66 356	Establishment Charges	27,71,799.11
	Contribution to :	
1,37,238	Employees' Provident Fund	1,80,530.00
11,583	Deposit Linked Insurance Fund	12,404.15
1,30,386	Group Gratuity Scheme	1,38,861.25
2,77,982	Conveyance Allowance to Doctors	2,82,251.50
		33,85,846.01
4,11,601	X-Ray Films & Chemicals	5,84,912.33
43,411	Laboratory Requisite	49,415.59
6,83,053	Drugs	11,35,259.38
425	Collection Charges	351.00
1,59,880	Diet Charges	1,56,952.33
30,830	Linen	48,656.70
2,91,861	Hospital Sundries	5,01,023.50
2,475	Blood Transfusion Charges	6,725.00
73,103	Medical Gas	94,908.01
6,200	Fuel Gas	7,508.05
50,941	Washing Charges	59,610.70
4,95,693	Electricity Charges	6,84,674.70
2,28,423	Canteen Expenses	2,89,703.25
		36,19,700.54
	<b>OTHER EXPENSES :</b>	
9,731	Telephone Charges	54,898.60
72,852	Printing and Stationery	99,821.23
8,123	Postage and Telegram	7,274.70
11,668	Freight Cooly Conveyance	14,452.20
8,563	Bank Charges & Interest on Bank Overdraft	3,780.80
10,800	Rent for Premises	10,800.00
11,912	Expenses on Employees' Provident Fund	14,361.30
1,505	Subscription Books & Periodicals	3,750.50
72	Advertisement Charges	1,832.00
1,110	Local Fund Audit Fee	1,018.00
3,000	Honorarium to Auditors	4,000.00
		2,15,989.33
	<b>C/o.</b>	<b>73,04,242.00</b>
<b>55,51,914</b>		

(REGISTERED) MADRAS—600 113

THE YEAR 31st MARCH, 1990

<i>As on</i> 31.3.89	<i>INCOME</i>	<i>As on</i> 31.3.90
	<b>BY COLLECTIONS :</b>	
19,13,409	Madras Race Club Hospital	32,22,475.72
4,40,481	Deluxe Unit	7,71,551.55
5,06,105	X-Ray Department	6,70,456.10
3,68,877	Medical Aid Plan	4,34,030.72
5,14,295	Diagnostic Centre, Adyar	7,07,646.63
1,16,416	Diagnostic Centre, Mylapore	1,20,944.00
		59,27,104.72
	<b>GRANTS :</b>	
	<b>From Tamilnadu Government :</b>	
	For Maintenance of Madras Race Club Hospital :	
6,00,000	Advance grant for 1989—90	6,00,000.00
3,00,360	Balance Grant for 1988—89	3,08,900.00
		9,08,900.00
46,481	For arrears of grant for the maintenance of Mini Health Centres	67,775.00
45,000	For Maintenance of Family Planning Beds	30,000.00
27,705	Subsidy for Diet, Drugs etc. on Family Planning Cases	46,155.00
5,000	From Tamilnadu Social Welfare Board for Tuberculosis Project	1,500.00
		10,54,330.00
48,84,129	<b>C/o.</b>	<b>69,81,434.72</b>

**THE VOLUNTARY HEALTH SERVICES  
INCOME AND EXPENDITURE ACCOUNT FOR**

<i>As on</i> 31.3.89	<i>EXPENDITURE</i>	<i>As on</i> 31.3.90
55,51,914	B/f.	73,04,242.00
	<b>TO OTHER ITEMS</b>	
3,63,350	Repairs, Renewals and Service Charges	4,43,515.85
29,627	Ambulance Expenses	23,010.92
69,482	Miscellaneous Expenses	51,649.49
37,680	Leprosy Research Expenses	548.30
100	Legal Expenses	3,100.00
		<u>5,21,824.56</u>
6,85,000	Expenses of MA Chidambaram Institute of Community Health	...
1,83,323	Contribution to USAID Project	1,11,820.96
	<b>ASSETS</b> Condemned and written off	
14,683	Equipments	37,273.30
50	Furniture	4,188.90
		<u>41,462.20</u>
	Depreciation on :	
3,55,945	Buildings	4,21,188.19
4,58,449	Equipments	6,24,173.77
33,149	Furniture	37,126.08
971	Kitchen Utensils	1,909.73
		<u>10,84,397.77</u>
		Rs. 90,63,747.49
<u>77,82,723</u>		

Annexure to our report of date

V. NATARAJAN  
Proprietor

AIYAR & CO.,  
Chartered Accountants  
Honorary Auditors

N.S. MURALI  
Hony. Secretary

MADRAS DATED JULY 17, 1990

(REGISTERED), MADRAS—600 113

THE YEAR 31st MARCH, 1990

<i>As on</i> 31.3.89	<i>INCOME</i>	<i>As on</i> 31.3.90
48,84,129	B/f.	69,81,444.72
7,04,899	Donations	53,610.54
8,78,706	Interest on Deposit	10,33,430.03
2,00,019	Dietary Department Collections	1,96,035.08
1,200	Subscriptions Life & Ordinary Membership	...
35,626	Ambulance Expenses	30,930.00
1,21,246	Miscellaneous Receipts	1,84,902.60
82,706	Closing Stock of Drugs as on 31st March, 1990 (Valued at cost)	14,105.03
		<u>84,93,548.00</u>
8,74,192	<b>EXCESS OF EXPENDITURE OVER INCOME</b>	5,70,199.49
<u>77,82,723</u>		Rs. 90,63,747.49

M. SUBRAMANIAM  
Hony. Treasurer

N. MAHALINGAM  
President

**THE VOLUNTARY HEALTH SERVICES-  
CONSOLIDATED RECEIPTS AND PAYMENTS ACCOUNT**

**RECEIPTS**

**TO OPENING BALANCES AS ON**

1st April, 1989 :

**Cash Balances :**

Cash on Hand including Imprest Cash 55,728.55

**Bank Balances :**

In Current and Savings Bank A/cs 25,16,642.14 25,72,370.69

**Subscriptions :**

Life Membership & Ordinary Membership ... 8,19,576.41

**Donations**

**GRANTS :**

**From Tamilnadu Government :**

a) Building Construction from Indian Population Project 5,08,000.00

b) For Maintenance of Urban Family Welfare Centre :

Advance grant for 1989—90 80,000.00  
Others 3,345.00 83,345.00

c) For Urban Health Posts :

Advance grant for 1989—90 74,577.00  
Advance grant for 1988—89 8,500.00 83,077.00

d) For Maintenance of Madras Race Club Hospital :

Advance grant for 1989—90 6,00,000.00  
Balance grant for 1988—89 3,08,900.00 9,08,900.00

C/o. Rs. 6,74,422.00 33,91,947.10

(REGISTERED), MADRAS—600 113

FOR THE YEAR ENDED 31st MARCH, 1990

**PAYMENTS**

**BY EXPENSES :**

Establishment Charges 6,14,919.65

**Contribution to :**

Employees' Provident Fund 39,426.00  
Deposit Linked Insurance Fund 2,641.40  
Group Gratuity Fund 29,569.00  
Conveyance Allowance to Doctors 1,28,394.80 8,14,950.85

Drugs Purchased 1,02,113.65  
Hospital Sundries 1,079.13  
X-Ray Films & Chemicals 3,72,759.83  
Laboratory Requisites 49,415.59  
Collection Charges 351.00  
Gas 1,146.10  
Linen 6,560.00  
Electricity Charges 2,11,429.00 7,44,854.30

**OTHER CHARGES :**

Rent for premises 10,800.00  
Printing & Stationery 45,300.27  
Postage & Telegram 4,600.30  
Subscriptions, Books & Periodicals 3,750.50  
Telephone Charges 13,751.80  
Freight Cooly and Conveyance 9,607.20  
Repairs, Renewals & Service Charges 1,40,552.10  
Bank Charges and Interest on Overdraft 1,116.50  
Advertisement Charges 788.00  
Miscellaneous Expenses 25,713.80  
Inauguration Expenses ...  
Honorarium to Auditors 3,000.00  
Expenses on Employees' Provident Fund 14,361.30  
Legal Expenses 3,100.00  
Leprosy Research Expenses 548.30 2,76,990.07

Contribution to USAID Project 1,11,820.96

C/o. 19,48,616.18

**THE VOLUNTARY HEALTH SERVICES  
CONSOLIDATED RECEIPTS AND PAYMENTS ACCOUNT**

RECEIPTS				
To	B/f.	9,08,900.00	6,74,422.00	33,91,947.10
For maintenance of Family Planning Beds :				
Advance grant for 1989—90		15,000.00		
Balance grant for 1988—89		15,000.00		
Subsidy for Diet. Drugs etc. on Family Planning Cases		46,155.00		
			9,85,055.00	
e) For Maintenance of Kottur Urban Medicare Centre :				
Advance grant for 1989—90		...		
Collections		10,734.05		
Advances		51,900.00		
			62,634.05	
f) For Community Health Project :				
Interest		49,613.03		
Others		76,835.00		
			1,26,448.03	
g) For Maintenance of Mini Health Centres :				
Arrears of grant received			67,775.00	
h) For Tuberculosis Projects :				
Grant from Tamilnadu Social Welfare Board			1,500.00	
			19,17,834.08	
<b>TO GRANTS :</b>				
i) From Government of India :				
Ministry of Health and FW for purchase of Equipments			2,00,000.00	
For Research on Variable and pulsating Magnetic Waves on Human Lives			...	
iii) Ministry of Environment & Forests—				
Research on Ecology and Environment				
Grants received		...		
Advances		6,448.26		
			6,448.26	
C o.		2,06,448.26	53,09,781.18	

(REGISTERED), MADRAS—600 113  
FOR THE YEAR ENDED 31st MARCH, 1990.

PAYMENTS			
By	B/f.	19,48,616.18	
<b>EXPENSES OF :</b>			
Madras Race Club Hospital (Sch. A)		56,40,616.63	
Dietary Department (Sch. B)		2,89,703.25	
USAID Project (Sch. C)		21,16,294.61	
			80,46,614.49
BUILDING Construction		16,60,809.84	
EQUIPMENTS Purchased		9,16,244.21	
FURNITURE Purchased		44,192.05	
KITCHEN UTENSILS Purchased		3,379.63	
			26,24,625.73
INVESTMENTS in Fixed Deposits		1,39,49,887.12	
MISCELLANEOUS Deposit		11,020.00	
			1,39,60,907.12
Staff Security Deposit		8,028.75	
GMT Caution Deposit		3,100.00	
Compensation paid for F.P. Operations		1,37,568.00	
Advances to staff for festivals		1,26,100.00	
Undisbursed Salaries		50,868.95	
Amount due to Family Welfare Staff		10,122.00	
			3,35,787.70
<b>REMITTANCE OF :</b>			
Incometax Collections		30,984.00	
Professional Tax		...	
Life Insurance Corporation—Salary Savings Scheme		19,485.80	
Employees Provident Fund		3,62,492.00	
Deposit Linked Insurance Fund		...	
Incometax deducted at Source on Interest on Deposit		2,718.00	
			4,15,679.80
C/o.		2,73,32,231.02	

**THE VOLUNTARY HEALTH SERVICES**  
**CONSOLIDATED RECEIPTS AND PAYMENTS ACCOUNT**

RECEIPTS			
To	B/f.	2,06,448.26	53,09,781.18
iv) From Ministry of Health (VOP) for USAID Project for Eradication of Leprosy and Tuberculosis Grants for 1989-90		15,67,537.00	
Indigenous Collection		4,65,595.76	
Others		36,540.00	
		20,69,672.76	22,76,121.02
<b>OTHER PROJECTS :</b>			
For Stroke Project :			
Donations		78,000.00	
Interest on Deposits		27,816.60	
		1,05,816.60	
For Cloquinol Project Donations			30,000.00
For Diabetic Project Interest on Deposits		32,301.73	
Others		7,945.00	
		40,246.73	1,76,063.33
Investments in Fixed Deposits			1,04,17,664.34
<b>RECEIPTS OF :</b>			
Madras Race Club Hospital (Sch. A)		37,02,029.96	
Dietary Department (Sch. B)		1,96,035.08	
		38,98,065.04	
<b>OTHER COLLECTIONS :</b>			
Deluxe Unit		7,71,551.55	
X-Ray		6,70,456.10	
Medical Aid Plan— Subscription		3,44,962.05	
O.P. Drug Sales		89,068.67	
		4,34,030.72	
Diagnostic Centre, Adyar		7,07,646.63	
Diagnostic Centre, Mylapore		1,20,944.00	
		27,04,629.00	
	C/o.		2,47,82,323.91

(REGISTERED), MADRAS—600 113  
FOR THE YEAR ENDED 31st MARCH, 1990

PAYMENTS		
By	B/f.	2,73,32,231.02
<b>ADVANCES :</b>		
Advance Collections from Patients		52,37,894.94
Advances for Purchases etc. Adjusted		21,46,849.73
Reserve for Donation Capitalised		8,928.00
		73,93,672.67
<b>EXPENSES AGAINST SPECIFIC GRANTS :</b>		
Urban Family Welfare Centre		1,32,132.05
Urban Health Pests		1,01,371.73
Urban Medicare Centre, Kottur		57,197.71
Ministry of Defence : Effects on Variable and Pulsating Magnetic waves on Human Bodies		65,649.62
Ministry of Environment & Forests Effects on Ecology and Environment		1,37,489.96
I.C.M.R./P.L. 480—Research on Non-volitional Biofeed Back Study on Higher Nervous Disorders		14,360.56
Arogya Ashrama Samiti—Research on Yoga and Biofeed Back		2,642.35
Community Health Project		61,127.85
		5,71,971.83
	C/o.	3,47,25,903.69

**THE VOLUNTARY HEALTH SERVICES**  
**CONSOLIDATED RECEIPTS AND PAYMENTS ACCOUNT**

<b>RECEIPTS</b>		
To	B/f.	2,47,82,323.91
<b>OTHER RECEIPTS :</b>		
Interest on Deposits	6,50,577.44	
Miscellaneous Receipts	1,51,536.95	
		8,02,114.39
Staff Security Deposits	5,336.60	
GMT Caution Deposits	3,200.00	
Festival Advances to Staff	1,10,740.00	
Incometax Collection from Contractors	30,984.00	
Incometax Deducted at source	2,679.00	
Life Insurance Corporation—Salary		
Savings Scheme	19,485.80	
Employees' Provident Fund	3,64,014.00	
Recoupement of Compensation paid for F.P. Operation	1,56,792.00	
Family Welfare Staff Account	10,122.00	
Undisbursed Salaries	50,468.80	
		7,53,822.20
<b>ADVANCES :</b>		
Advance Collections from patients	55,83,328.91	
Advances for purchase etc. Adjusted	22,78,591.04	
		78,61,919.95
Maintenance Reserve Account	17,93,302.91	
Reserve for donations capitalised	4,59,716.82	
Dr. K.S. Sanjivi Endowment Lecture Fund	15,000.00	
SABRA Fund	30,000.00	
Cardiac Research Fund	20,000.00	
Sri Varesiddhi Vinayagar Temple Fund	4,000.00	
Diabetic Project Fund	56,396.00	
		23,78,415.73
	C/o.	3,65,78,596.18

(REGISTERED), MADRAS—600 113  
FOR THE YEAR ENDED 31st MARCH, 1990

<b>PAYMENTS</b>			
By	B/f.	5,71,971.83	3,47,25,903.69
M.A. Chidambaram Institute of Community Health			
Stroke Project			97,491.76
Cliquinol Project			8,997.00
Diabetic Project			1,71,016.16
VHS Bulletin Account			6,037.45
Teaching Programme			26,591.55
Multi Purpose Health Worker Training			52,500.00
Nursing Assistant Training Programme			4,995.00
Sri Varasiddhi Vinayagar Temple A/c			10,216.50
J. Srinivasan Cardiac Research A/c			20,000.00
SABRA Account			30,000.00
Dr. Subramanian Suresh Library A/c			458.25
Bank of Baroda Medical Relief A/c			1,95,871.10
Dr. K.S. Sanjivi Endowment Lecture A/c			26,978.50
Guruswami Naidu Medical Relief A/c			7,000.00
VHS Silver Jubilee Celebration A/c			1,28,799.24
			13,58,924.34
	C/o.		3,60,84,828.03

**THE VOLUNTARY HEALTH SERVICES  
CONSOLIDATED RECEIPTS AND PAYMENTS ACCOUNT**

RECEIPTS

To	B/f.	3,65,78,596.18
Sri Varasiddhi Vinayagar Temple A/c	5,827.05	
Teaching Programme	39,997.50	
Multipurpose Health Worker Training A/c	1,33,200.00	
VHS Bulletin Account	8,743.13	
Dr. Subramanian Suresh Library A/c	2,050.10	
SABRA Account	20,696.28	
J. Srinivasan Cardiac Research A/c	18,987.82	
Bank of Baroda Medical Relief A/c	1,92,993.00	
Dr. K.S. Sanjivi Endowment Lecture A/c	19,319.77	
Capt. S. Jayaram Endowment Account	1,660.25	
Sri Vepa Ramesam Nutrition and Dietetics A/c	440.00	
VHS Silver Jubilee Celebration Account	81,200.00	
	5,28,114.90	

Rs. 3,71,06,711.08

Examined and found correct as per books maintained by the Voluntary Health Services Madras.

V. NATARAJAN  
Proprietor

N.S. MURALI  
Hony. Secretary

AIYAR & CO.,  
Chartered Accountants  
Honorary Auditors

MADRAS DATED JULY 17, 1990

(REGISTERED), MADRAS—600 113  
FOR THE YEAR ENDED 31st MARCH, 1990.

PAYMENTS

By	B/f.	3,60,84,528.03
<b>CLOSING BALANCES AS ON 31st March, 1990</b>		
<b>Cash Balance :</b>		
Cash on Hand including Imprest Cash	37,411.50	
<b>Bank Balances :</b>		
In Current and Savings Bank Accounts	9,84,471.55	10,21,883.05

Rs. 3,71,06,711.08

M. SUBRAMANIAM  
Hony. Treasurer

N. MAHALINGAM  
President

THE VOLUNTARY HEALTH SERVICES

MADRAS RACE CLUB

Particulars of Receipts and Payments Account for

RECEIPTS	
To Hospital Collections (Less Refunds)	32,22,475.72
Miscellaneous Receipts	33,365.65
Donations	33,306.00
Interest on Deposits	3,82,852.59
Ambulance Receipts	30,030.00
	<u>37,02,029.96</u>
GRANT from Tamilnadu Government :	
For maintenance of Madras Race Club Hospital :	
Advance Grant for 1989—90	6,00,000.00
For maintenance of Family Planning Beds	
Grant from Tamilnadu Government :	30,000.00
Subsidy for Diet, Drugs etc. on	
Family Planning Cases	46,155.00
	<u>76,155.00</u>
	<u>43,78,184.96</u>
Deficit (Excess of Expenditure Over Income)	12,62,431.67
	<u>Rs. 56,40,616.63</u>

(REGISTERED), MADRAS—600 113

SCHEDULE "A"

HOSPITAL ACCOUNT

the year ended 31st March 1990 (Revenue Items)

PAYMENTS	
By Establishment Charges	22,48,332.96
Contribution to :	
Employees' Provident Fund	1,41,104.00
Deposit Linked Insurance Fund	9,762.75
Group Gratuity Scheme	1,09,292.25
Conveyance Allowance to Doctors	1,67,756.70
Drugs	10,20,494.79
Hospital Sundries	4,99,944.37
Linen	42,096.70
X-Ray and Chemicals	2,12,152.50
Blood Transfusion Charges	6,725.00
Diet Charges	1,56,952.33
Medical Gas	94,908.01
Fuel Gas	6,361.95
Washing Charges	59,610.70
Electricity Charges	4,73,245.70
Telephone Charges	41,146.80
Printing and Stationery	54,520.96
Postage and Telegrams	2,674.40
Advertisement Charges	1,044.00
Bank Charges and Interest on Bank Overdraft	2,664.30
Local Fund Audit Fee	1,018.00
Subscription Books & Periodicals	---
Freight Cooly and Conveyance	4,845.00
Repairs Renewals Service Charges	2,35,015.85
Ambulance Expenses	23,010.92
Miscellaneous Expenses	25,935.69
	<u>Rs. 56,40,616.63</u>

THE VOLUNTARY HEALTH SERVICES

DIETARY

Particulars of Receipts and Payments Account for

<u>RECEIPTS</u>	
To Diet Charges	1,67,642.68
Miscellaneous Receipts	970.40
	1,68,613.08
Coupon Sales to Staff	11,800.00
Subsidy	15,622.00
	27,422.00
	1,96,035.08
Deficit (Excess of Expenditure over income)	93,668.17
	Rs. 2,89,703.25

(REGISTERED), MADRAS—600 113

SCHEDULE "B"

DEPARTMENT ACCOUNT

the year ended 31st March, 1990

<u>PAYMENTS</u>	
By Establishment Charges	29,607.20
Contribution to :	
Employees' Provident Fund	1,519.00
Deposit Linked Insurance Fund	95.85
Group Gratuity Scheme	1,073.00
Printing and Stationery	1,820.66
Postage and Telegram	34.60
Payment for Coupons to Staff	21,200.00
Printing of Coupon Books	...
<b>KITCHEN EXPENSES :</b>	
Vegetables	20,450.10
Fruits, Bread, Eggs, etc.	28,063.45
Provisions	89,971.50
Milk	86,345.00
Fuel	5,675.15
Repairs, l	2,990.64
Freight C	78.00
Miscellan	770.10
	Rs. 2,89,703.25



ESTIMATED AIDSCAP BUDGET

(Years 1 - 7)

RESIDENT ADVISOR	\$475,903
CONSULTANCIES	\$1,110,084
STUDY TOURS/TRAINING/ CONFERENCES	\$707,250
	-----
TOTAL	\$2,293,237
	-----

## INDIA: PROPOSED BUDGET FOR RESIDENT ADVISOR

Budget in US dollars:

CATEGORY	YEAR:1	2	3	4	5
Salary	25,000	26,250	27,563	28,941	30,388
Benefits @ 25%	6,250	6,563	6,891	7,235	7,597
Orientation Travel:					
In Washington (one month)					
Travel @ \$5,500	5,500				
Per diem (32 days @ \$144)	4,608				
At Asia Regional Office (two weeks)					
Travel @ \$750	750				
Per diem (16 days @ \$163)	2,608				
Operational Travel:					
Annual two-week trip to Washington					
Travel @ \$5,500	5,500	5,500	5,500	5,500	5,500
Per diem (18 days @ \$144)	2,592	2,592	2,592	2,592	2,592
2 per yr. one-week trips to Asia Regional Office					
Travel @ \$750 each	1,500	1,500	1,500	1,500	1,500
Per diem (8 days @ \$163)	2,608	2,608	2,608	2,608	2,608
G&A @ 34.7%	19,750	15,620	16,189	16,786	17,414
<b>TOTAL</b>	<b>76,666</b>	<b>60,633</b>	<b>62,843</b>	<b>65,162</b>	<b>67,599</b>

CATEGORY	YEAR:6	7	TOTAL
Salary	31,907	33,502	203,551
Benefits @ 25%	7,997	8,376	50,889
Orientation Travel:			
In Washington (one month)			
Travel @ \$5,500	5,500		5,500
Per diem (32 days @ \$144)	4,608		4,608
At Asia Regional Office (two weeks)			
Travel @ \$750	750		750
Per diem (16 days @ \$163)	2,608		2,608

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Operational Travel:

Annual two-week trip to Washington				
Travel @ \$5,500	5,500	5,500	38,500	
Per diem (18 days @ \$144)	2,592	2,592	18,144	
2 per yr. one-week trips to Asia Regional Office				
Travel @ \$750 each	1,500	1,500	10,500	
Per diem (8 days @ \$163)	2,608	2,608	18,256	
Sub-Total	52,084	54,078	353,306	
G&A @ 34.7%	18,073	18,765	122,597	
<b>TOTAL</b>	<b>70,157</b>	<b>72,843</b>	<b>475,903</b>	

Note that vehicle(s) and office expenses are assumed covered under other items in the PP budget. Consultant fees and study tours/participant training are not included in this budget.

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**AIDSCAP TECHNICAL ASSISTANCE COSTS**  
**OUTSIDE BILATERAL AGREEMENT**

<b>1.</b>	<b>Counseling Modules</b>			
	7	2-week trips from Washington		
		Personnel @	\$9,000	
		Travel @	\$5,000	
		Total		\$98,000
<b>2.</b>	<b>STDs</b>			
		King Holmes		
	9	2-week trips from Seattle		
		Personnel @	\$9,000	
		Travel @	\$5,000	
		Total		\$126,000
		Doris Mugrditchiam, 2-week trips from Bangkok		
	10	2-week trips from Bangkok		
		Personnel @	\$7,500	
		Travel @	\$1,500	
		Total		\$90,000
<b>3.</b>	<b>Mass Communication</b>			
	7	2-week trips from Bangkok		
		Personnel @	\$7,500	
		Travel @	\$1,500	
		Total		\$63,000
<b>4.</b>	<b>Evaluation</b>			
	10	2-week trips from Bangkok		
		Personnel @	\$7,500	
		Travel @	\$1,500	
		Total		\$90,000
	7	2-week trips from Bangkok		
		Personnel @	\$4,000	
		Travel @	\$1,500	
		Total		\$38,500

**AIDSCAP TECHNICAL ASSISTANCE COSTS**  
**OUTSIDE BILATERAL AGREEMENT**

**5. Supervision**

7 2-week trips from Bangkok  
Personnel @ \$7,500  
Travel @ \$1,500  
Total \$63,000

7 1-week trips from Washington  
Personnel @ \$5,000  
Travel @ \$5,000  
Total \$70,000

**6. Selected modelling and research activities**

21 1-week trips from Washington  
Personnel @ \$5,000  
Travel @ \$5,000  
Total \$210,000

**7. Study Tours (personnel includes only per diem; it is assumed that salary costs will be met by GOI, GOTN, or APAC)**

**A. GOI AIDS officials**

8 2-week trips to USA  
Personnel @ \$3,000  
Travel @ \$5,000  
Total \$64,000

6 2-week trips to Africa  
Personnel @ \$2,000  
Travel @ \$5,000  
Total \$42,000

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**AIDSCAP TECHNICAL ASSISTANCE COSTS**  
**OUTSIDE BILATERAL AGREEMENT**

**B. Government of Tamil Nadu/NGO staff**

10	2-week trips to Washington, D.C.		
	Personnel @	\$3,000	
	Travel @	\$5,000	
	Total		\$80,000

10	2-week trips to Africa		
	Personnel @	\$2,000	
	Travel @	\$5,000	
	Total		\$70,000

**C. Training and conference**

15	2-week trips to USA		
	Personnel @	\$3,000	
	Travel @	\$5,000	
	Total		\$120,000

28 1-week trips for conferences

7	to USA		
	Personnel @	\$2,000	
	Travel @	\$5,500	
	Total		\$52,500

7	to Europe (Paris)		
	Personnel @	\$2,000	
	Travel @	\$3,000	
	Total		\$35,000

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**AIDSCAP TECHNICAL ASSISTANCE COSTS**  
**OUTSIDE BILATERAL AGREEMENT**

C.	Training and conference (Contd.)		
7	to Asia (Bangkok)		
	Personnel @	\$1,500	
	Travel @	\$2,000	
	Total		\$24,500
7	to Africa (Nairobi)		
	Personnel @	\$1,500	
	Travel @	\$2,000	
	Total		\$24,500
	Subtotal		\$1,361,000
	G&A @ 31%		\$421,910
	TOTAL		\$1,782,910

Note: Costs are calculated to include Ticket cost, Per diem, Incidentals and Salary.

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**CONDITIONS PRECEDENT AND COVENANTS**

**A. Conditions Precedent:** The Project Agreement shall provide:

Prior to the first disbursement under the Project Grant Agreement, or to the issuance by A.I.D. of documentation pursuant to which disbursement will be made, the Cooperating Country will, except as the Parties may otherwise agree in writing, furnish to A.I.D. in form and substance satisfactory to A.I.D.:

1. a statement of the name(s) of the person(s) holding or acting in the office(s) of the Grantee identified in Section 8.2 of the Agreement, and of any additional representatives, together with a specimen signature of each person in such statement; and
2. a letter from the Grantee naming: (1) a representative from the Government of Tamil Nadu (GOTN) to chair the Project Management Committee (PMC) and an alternate Chairman; and (2) a representative from the Ministry of Health and Family Welfare (MOHFW) to represent the National AIDS Control Programme (NACO) on the PMC.

**B. Covenants:** The Project Agreement shall contain the following covenants:

1. Reporting of Grantee's Project Contribution: The Grantee agrees to furnish to A.I.D. in writing, annually during the life of the Project, a report of the Grantee's contribution (in cash and in kind) which is provided pursuant to Section 3.2 of the Project Agreement. The format and content of such report will be specified in a Project Implementation Letter.
2. Evaluations: Within eighteen (18) months of the date of this Agreement, the Grantee will establish a monitoring and evaluation program which will be financed as part of the Project. Except as the Parties may otherwise agree in writing, this program will include an in-depth mid-term evaluation and a final evaluation at the end of the Project. The monitoring and evaluation program will include:
  - a. An evaluation of the progress towards attainment of the objectives of the Project;

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- b. Identification and evaluation of problem areas or constraints which may inhibit such attainment.
  - c. Assessment of how such information may be used to help overcome such problems or constraints; and
  - d. Evaluation, to the degree feasible, of the overall development impact of the Project.
3. Training: The Grantee shall make all training under the Project available to their personnel without any discrimination on the basis of gender.
4. Use of Training: The Grantee shall exercise every effort to require that each of their personnel trained under the Project shall work in activities related to the Project or in activities approved for financing under the Project Grant Agreement, in India, for not less than three times the length of his or her training program.

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