

PD ART-274 ADW

AMENDMENT NO. 4

A.I.D. Project No. 367-0157

Child Survival/Family
Planning Services

The Project Grant Agreement, No. 367-0157, dated June 29, 1990 between His Majesty's Government of Nepal ("HMG/N" or "Grantee") and the United States of America, acting through the Agency for International Development ("A.I.D.") was last amended on August 28, 1991. The Project Grant Agreement is hereby further amended as follows:

1. To increase the life-of-project funding by \$2,500,000, to increase the obligation by \$2,450,000 (Attachment 1 hereto), and make other modifications to the Agreement.
2. Article 2, The Project, Section 2.2, Incremental Nature of Project, is amended by deleting the A.I.D.'s contribution to the Project "Twenty Million U.S. Dollars (\$20,000,000)" and substituting therefor "Twenty-Two Million Five Hundred Thousand U.S. Dollars (\$22,500,000)."
3. Article 3, Financing, Section 3.1, The Grant, delete the first sentence and insert in lieu thereof the following:

"To assist HMG/N to meet the costs of carrying out the Project, A.I.D., pursuant to the Foreign Assistance Act of 1961, as amended, agrees to grant HMG/N under the terms of this Agreement not to exceed Fourteen Million Two Hundred Forty-Three Thousand Two Hundred Forty-Three U.S. Dollars (\$14,243,243), hereinafter referred to as the 'Grant'. From this total Six Hundred Sixty-Two Thousand One Hundred Nine U.S. Dollars (\$662,109) will be applied by A.I.D./Washington to the procurement of contraceptive commodities."
4. Article 3, Financing, Section 3.2, HMG/N Resources for the Project, (b), is amended by deleting "Twenty Million Seven Hundred Seventy-Nine Thousand U.S. Dollars (\$20,779,000)" and substituting therefor "Twenty-Two Million Four Hundred Seventy-Three Thousand U.S. Dollars (\$22,473,000)."
5. To add to Annex 1, Amplified Project Description, the attached description of Vitamin A activities (Attachment 2 hereto) under Section I.B, Project Components. In addition, Attachment A (Illustrative Financial Plan) to Annex 1, is deleted in its entirety and an amended Attachment A is substituted in lieu thereof.

6. The Project Grant Standard Provisions, Annex 2 to the original Agreement, Section B.5. Reports, Records, Inspections, Audit, is deleted in its entirety and the attached new Section B.5. Reports, Accounting Records, Audits, Inspections (Attachment 3 hereto) is substituted in lieu thereof.
7. Except as specifically amended or modified herein, the Project Grant Agreement, as previously amended on September 24, 1990, June 10, 1991, and on August 28, 1991, shall remain in full force and effect.

IN WITNESS WHEREOF, His Majesty's Government of Nepal and the United States of America, each acting through its respective duly authorized representatives, have caused this Amendment to be signed in their names and delivered as of the date last written below.

ON BEHALF OF HIS MAJESTY'S
GOVERNMENT OF NEPAL

ON BEHALF OF THE UNITED
STATES OF AMERICA

BY: for R. Nath Pant
Thakur Nath Pant.

BY: Kelly C. Kammerer
Kelly C. Kammerer

TITLE: Secretary
Ministry of Finance

TITLE: Director
USAID/Nepal

DATE: 28 August 1992

DATE: 8/31/92

Child Survival/Family Planning Services Project - Grant Agreement

Illustrative Financial Plan

Category	LOP	Adjustment	Revised LOP	Increase in LOP	Revised LOP	Obligation Thru A#3	This Obligation	Total Obligation
Technical Assistance	5,520,000	1,254,000	6,774,000	680,000	7,454,000	6,422,105	280,000	6,702,105
Training	1,417,000	(400,000)	1,017,000	390,000	1,407,000	70,500	390,000	460,500
Commodities/Supplies*	4,660,000	- -	4,660,000	50,000	4,710,000	1,166,214	300,200	1,466,414
Local Cost Support	4,820,000	(876,000)	3,944,000	400,000	4,344,000	2,299,421	500,000	2,799,421
Construction	500,000	296,000	796,000	- -	796,000	796,000	- -	796,000
Evaluations	150,000	50,000	200,000	- -	200,000	100,000	- -	100,000
Audit	75,000	- -	75,000	- -	75,000	40,000	- -	40,000
Inflation	1,711,000	(700,000)	1,011,000	274,000	1,285,000	- -	274,000	274,000
Local NGO/PVO & CA	- -	876,000	876,000	600,000	1,476,000	876,200	599,800	1,476,000
Contingency	1,147,000	(500,000)	647,000	106,000	753,000	22,803	106,000	128,803
TOTAL PROJECT COST	20,000,000	- -	20,000,000	2,500,000	22,500,000	11,793,243	2,450,000	14,243,243

* From the total obligation, six hundred sixty-two thousand one hundred nine U.S. Dollars (\$662,109) have been applied by AID/Washington to the procurement of contraceptive commodities.

In FY 91, four hundred sixty-two thousand U.S. Dollars (\$462,000) were provided by AID/Washington from other sources for the procurement of contraceptive commodities.

ANNEX 1

AMPLIFIED PROJECT DESCRIPTION

CHILD SURVIVAL/FAMILY PLANNING SERVICES
VITAMIN A COMPONENT

TABLE OF CONTENTS

	<u>Page</u>
I. EXECUTIVE SUMMARY	
A. Introduction and Background	1
B. Project Components	2
C. Expected Results	3
II. CURRENT STATUS OF VITAMIN A ACTIVITIES IN NEPAL	
A. Research Activities	3
B. On-Going Programs	4
C. Institutional and Multisectoral Approaches	5
D. USAID and HMG Objectives	5
III. ACTIVITY DESCRIPTION	
A. Project Goal and Purpose	6
B. Vitamin A Activities	6
C. Expected Results	10
D. Summary of Inputs	11
E. Financial Plan	12
IV. IMPLEMENTATION PLAN	
A. Implementation Schedule	15
B. Implementation Management	16
C. Contracting Modalities	16
D. Monitoring, Evaluation and Audit Plans	17

GLOSSARY

CHV	-	Community Health Volunteer
CRHD	-	Central Regional Health Directorate
FP	-	Family Planning
HKI	-	Helen Keller International
HP	-	Health Post
HMG	-	His Majesty's Government
JNSP	-	Joint Nutrition Support Program
JSI	-	John Snow Incorporated, Inc.
MOH	-	Ministry of Health
MCH	-	Maternal and Child Health
NNIPS	-	Nepal Nutrition Intervention Project, Sarlahi
NNJS	-	Nepal Netra Jyoti Sangh
NNPCC	-	National Nutrition Policy Coordination Committee
NPC	-	National Planning Commission
NHRC	-	National Health Research Council
PHD	-	Public Health Division
SCF	-	Save the Children Fund
SHP	-	Sub Health Post
TA	-	Technical Assistance
UNICEF	-	United Nations International Children's Emergency Fund
VACSP	-	Vitamin A Child Survival Project
VHW	-	Village Health Workers

ANNEX 1

I. EXECUTIVE SUMMARY

A. Introduction and Background

Vitamin A deficiency is a common problem among children of many developing countries, especially in Asia. Recent studies have suggested that even mild non-corneal xerophthalmia or subclinical deficiency of vitamin A may also be associated with increased risk of both mortality and morbidity from illnesses such as measles, lower respiratory infections and diarrhea.

Beginning in 1980 with the first nationwide Nepal Blindness Survey, several studies have been conducted in Nepal to assess the extent of vitamin A deficiency and the prevalence of its ocular signs. The various studies reported xerophthalmia rates ranging from 1.3% to 2.9% (WHO criteria recognize vitamin A deficiency as a problem of public health significance when prevalence is greater than 1%).

Research studies conducted in Nepal have demonstrated significant reductions in pre-school mortality rates with vitamin A supplementation. Other studies have collected data on the cost effectiveness of different strategies to control vitamin A deficiency. Nepal's public health system supports a limited program of vitamin A capsule distribution. Several national and international NGOs have been active in addressing issues related to the control of vitamin A deficiency and its consequences, but their geographic reach has been limited. The various ministries involved in food production and consumption, and in nutrition education, are coordinated by the National Nutrition Policy Coordination Committee (NNPCC), under the National Planning Commission (NPC).

Nepal has been host to world class research on the effectiveness of vitamin A supplementation and on cost effective methods of distribution (AID has provided major support for this research). With countries world wide using Nepal-specific information for their planning and programming, it is appropriate for Nepal to apply its own country-specific findings to address significant vitamin A deficiency needs. USAID has already been instrumental in assisting the MOH to bring together a multisectoral group, including international expertise, to review findings and relevant applications for Nepal. This has resulted in a draft policy and implementation strategy for vitamin A deficiency eradication, which is currently being formally processed for inclusion into Nepal's Eighth 5-Year Plan.

The MOH statement referred to above contains recommendations for the short/medium term, long term, and for program monitoring and evaluation, and is summarized herein.

- a) Short/medium term approach: supplementation through mass distribution of vitamin A capsules.
- b) Long term approach: adult literacy, nutrition education, home gardening, disease prevention.

- c) Program monitoring and evaluation: baseline survey, indicators, monitoring at the field level and intermittent evaluations.

B. Project Components

The goal of the activities described in this project paper amendment remains unchanged from that in the project description, i.e., to reduce child mortality and undesired fertility. The purpose of this amendment is to decrease the prevalence of childhood diseases associated with vitamin A deficiency.

Project components will support research and operational studies that will provide information for further refinements to programming; assist the MOH with the implementation of a viable vitamin A intervention program; and strengthen national level planning, coordination and implementation.

1. Research and Analysis

Earlier studies in Nepal and elsewhere have shown significant reductions in childhood mortality with vitamin A supplementation. However, the degree to which maternal vitamin A deficiency, and therefore, deficiency in utero, contributes to fetal wastage, is not known. Research on the effects of controlling vitamin A deficiency in utero and in early infancy on fetal and infant health and survival is scheduled to be conducted in Nepal, beginning late 1992/early 1993. This project will support aspects of this research primarily through up-grading in-country vitamin A and beta carotene assessment capabilities.

2. Nationwide Vitamin A Deficiency Prevention Program

Vitamin A programs are part of overall nutrition interventions under the MOH/PHD. In partnership with UNICEF and other donors, USAID will support a nationwide effort to increase awareness among health service providers and the public of the importance of vitamin A nutriture, to distribute capsules and to promote preventive options. There will be three major aspects of this assistance: 1) short term interventions involving vitamin A capsule distribution; 2) development of alternatives for long term, preventive measures; and 3) coordination, planning and implementation.

Short term activities will consist of assistance for the planning, implementation, monitoring and evaluation of a vitamin A capsule distribution program. Districts will be prioritized for selection based on population density, accessibility and available infrastructure, and the potential for developing a practical and flexible timetable for capsule distribution. Health workers will be trained in vitamin A dosing, supervision, management and record keeping.

Long term activities will work towards a sustainable system to control vitamin A deficiencies. These are aimed at both behavioral and dietary changes in Nepal. New sanitation health practices, consumption of vitamin A-rich foods, and improved health services are the essential ingredients to such a system. Through a combination of educational programs (adult literacy, Mother Groups, nutrition/sanitation education programs by CHVs and local health staff, and home gardening) and MOH staff training and enhanced public

health services, people will be reached and the messages, hopefully, will be incorporated as permanent behavior changes. A coordinating unit to oversee implementation will be supported through the project. Strengthening of the NNPCC and establishment of a Technical Coordinating Committee will guide, on a permanent basis, all vitamin A activities. These committees will be supported through the project.

The costs of these activities, described in summary form, are estimated as follows (in \$,000's).

<u>Component</u>	<u>USAID Dollar Costs</u>	<u>USAID Rupee Costs</u>	<u>GON Rupee Costs</u>	<u>Total Costs</u>
Technical Assistance	600	80	135	815
Training	190	200	18	408
Commodities & Supplies	-0-	50	1,000	1,050
Local Cost Support	-0-	400	69	469
PVO Grants	-0-	600	180	780
Contingency	39	67	70	176
Inflation	<u>100</u>	<u>174</u>	<u>222</u>	<u>496</u>
Vitamin A Total	929	1,571	1,694	4,194

C. Expected Results

Through the activities described, the health service delivery system in selected regions will be better able to treat and prevent vitamin A deficiencies (in at least ten districts). In these locations, a reduction of at least 25% in vitamin A deficiency prevalence is projected. It is expected that proper health practices and nutritional changes will be adopted by the populace reached through the program and that the gains made will therefore be sustained.

II. CURRENT STATUS OF VITAMIN A ACTIVITIES IN NEPAL

A. Research Activities

Vitamin A deficiency is a common problem among children of many developing countries, especially in Asia. Recent studies have suggested that even mild non-corneal xerophthalmia or subclinical deficiency of vitamin A may also be associated with increased risk of both mortality and morbidity from such illnesses such as measles, lower respiratory infections and diarrhea.

Beginning in 1980 with the first nationwide Nepal Blindness Survey, several studies have been conducted to assess the extent of vitamin A deficiency and the prevalence of its ocular signs. A 1981-82 survey conducted by Tribuvan University's Institute of Medicine reported the national prevalence of xerophthalmia to be 1.3% among pre-school children. Mass screening for xerophthalmia was carried out during a vitamin A capsule distribution campaign in 1988 (in conjunction with the SEVA Foundation eye care program) in three districts of west central Terai. The xerophthalmia rate ranged from 1.5-1.9% (WHO criteria recognize vitamin A deficiency as a problem of public health significance when prevalence is greater than 1%).

An ocular survey by the Nepal Nutrition Intervention Project Sarlahi (NNIPS) was conducted in 1989-90. The prevalence of xerophthalmia among approximately 5,500 children below 6 years of age examined was 2.9%. The NNIPS also carried out a community trial to assess the impact of three annual vitamin A supplements on pre-school mortality, morbidity and growth. A reduction of 30% in mortality rate was observed. In accord with the NNIPS investigation, the Jumla control trial study found a reduction of 26% in mortality rate after single dose supplements in the 1-59 months age group. (For further information on these surveys and trials, see references cited in Annex C.)

The Vitamin A Child Survival Project (VACSP), a longitudinal intervention study to assess the effectiveness of different strategies to control vitamin A deficiency implemented by the Nepal Netra Jyoti Sangh (NNJS), measured program cost and changes in general indicators of health under four different program interventions (see reference nos. 11 and 12 cited in Annex C.).

B. On-Going Programs

The Nutrition Section of the Ministry of Health maintains a program of vitamin A capsule supplementation to children under 5 years of age. Due to funding constraints, coverage is limited to varying levels of activities in 34 districts. The MOH/Nutrition Section has also distributed approximately 30,000 packets of vegetable seeds to encourage the production of vitamin A-rich foods in home gardens. In addition, the Joint Nutrition Support Program, with funding from UNICEF, has provided vitamin A supplementation in 5 districts.

Several national and international non-governmental organizations (e.g., Nepal Netra Jyoti Sangh (NNJS), Save-the-Children/U.S. (SCF/US), Helen Keller International (HKI), and CARE) are implementing programs linked to the control of vitamin A deficiency and its consequences. Their major approaches include:

- vitamin A deficiency prevention actions in partnership with prevention and control of blindness;
- actions as part of integrated Primary Health Care activities, using or complementing existing government health care facilities;
- actions focused on measures for production, distribution and consumption of vitamin A-rich foods at the household level;

- actions to increase the level of awareness about the seriousness of the problem and its solution through information, education and communication (IE&C) activities;
- developing human resource skills (at professional, middle level management and field worker levels) required for addressing vitamin A deficiency problems; and
- increasing the level of income at households as part of community development efforts along with production, consumption and nutrition education.

C. Institutional and Multisectoral Approaches

Because of the magnitude of problems related to food production and consumption, a National Nutrition Policy Coordination Committee (NNPCC) under the National Planning Commission (NPC) has been created to coordinate all relevant ministries involved in this field. For example, the Ministry of Agriculture, through the Joint Nutrition Support Program (JNSP), encourages the production and consumption of vitamin A-rich foods at the household and community level. The Women's Development Division of the Ministry of Local Development supports a Production Credit for Rural Women program to improve the socio-economic status of women in particular and families in general, including a nutrition and health education component. The Nutrition Education Program at the Ministry of Education and Culture, Nutrition Section, implements primary education projects in six districts to improve health, and both formal and informal nutrition education programs.

Vitamin A capsule delivery is commonly accepted as the immediate short-term intervention of choice. Promotional campaigns to expand vitamin A capsule coverage and social marketing programs using media campaigns have been used successfully. By examining community attitudes and behavior, a multi-media strategy or campaign can affect knowledge and behavioral change.

Food fortification is an alternative approach to vitamin A deficiency. As a passive intervention that does not require behavioral change, coverage and effectiveness are somewhat simplified. Cost recovery of fortification is a sensitive issue requiring government subsidies or cost sharing by the consumer and may not be self sustaining.

Home gardening has proven to be an effective approach in increasing vitamin A rich food consumption, but does require significant changes in behavior, consumption, and use of limited local resources.

D. USAID and HMG Objectives

Nepal has been host to world class research on the effectiveness of vitamin A supplementation and on cost efficient methods of distribution (AID has provided major support for this research). With countries world wide using Nepal-specific information for their planning and programming, it is appropriate for Nepal to apply its own country-specific

findings to address significant vitamin A deficiency needs. USAID has already been instrumental in assisting the MOH to bring together a multisectoral group, including international expertise, to review findings and relevant applications for Nepal. This has resulted in a draft policy and implementation strategy for vitamin A deficiency eradication, which is currently being formally processed for inclusion into Nepal's Eighth 5-Year Plan.

The MOH statement referred to above contains recommendations for the short/medium term, long term, and for program monitoring and evaluation, and is summarized herein.

- a) Short/medium term approach: supplementation through mass distribution of vitamin A capsules. The goal of a short term intervention is to reduce child mortality and prevent blindness due to vitamin A deficiency.
- b) Long term approach: adult literacy, nutrition education, home gardening, disease prevention. Long term interventions are intended to improve nutritional status and prevent vitamin A deficiency diseases;
- c) Program monitoring and evaluation: baseline survey, indicators, monitoring at the field level and intermittent evaluations. The feedback provided would be used to modify elements of the vitamin A intervention program.

An important tool for all elements of the program is maintenance of a national coordinating unit to oversee implementation and various agencies' activities and to maintain a link with the National Planning Commission for high level policy support.

III. ACTIVITY DESCRIPTION

A. Project Goal and Purpose

The goal of the activities described in this project paper amendment remains unchanged from that in the project description, i.e., to reduce child mortality and undesired fertility. The purpose of this amendment is to decrease the prevalence of childhood diseases associated with vitamin A deficiency.

B. Vitamin A Activities

1. Research and Analysis

Earlier research in Nepal and other countries around the world have investigated the increased risk of infection and mortality from Vitamin A deficiency. The studies have shown significant reductions in childhood (age 6 months to 72 months) mortality with vitamin A supplementation. This dramatic impact of vitamin A is likely to be mediated by enhanced resistance to infection.

The degree to which maternal vitamin A deficiency, and therefore, deficiency in utero, contributes to fetal wastage, intrauterine growth retardation and early infant mortality in humans is not known. However, limited observations (maternal serum retinol levels, fetal autopsies, infant circulating vitamin A levels, etc.) suggest that maternal vitamin A deficiency may place the fetus at a higher risk of growth failure and mortality. In addition to infants, there are important questions related to the impact of improved vitamin A nutriture on maternal health and survival (in Nepal, maternal mortality estimated at 830/100,000 livebirths is 150% higher than for low income countries as a group, and is among the highest in the world).

One indirect approach to control vitamin A deficiency in utero and in early infancy, and to improve maternal vitamin A nutriture, is to ensure adequate vitamin A levels in the mother during pregnancy and lactation. A randomized, community vitamin A supplementation trial is proposed for implementation in Nepal (subject to National Health Research Council approval) to answer important questions about the benefits of improved maternal vitamin A nutriture prior to conception and throughout pregnancy on fetal and infant health and survival and, to a more limited extent, maternal health. This project will support aspects of this research through, e.g., training, supervision and follow-up of local women capsule distributors, and/or up-grading vitamin A and beta carotene assessment capabilities (in serum/plasma, food, breastmilk, etc.) of the Central Food Research Laboratory (CFRL).

2. Nationwide Vitamin A Deficiency Prevention Program

Vitamin A programs are part of overall nutrition interventions under the MOH/PHD. In partnership with UNICEF and other donors, USAID will support a nationwide effort to

increase awareness among health service providers and the public of the importance of vitamin A nutriture, to distribute capsules and to promote preventive options. There will be three major aspects of this assistance: 1) short term interventions involving vitamin A capsule distribution; 2) development of alternatives for long term, preventive measures; and 3) coordination, planning and implementation.

a) Short term: Vitamin A distribution and deficiency prevention activities will be integrated into the existing MOH training, personnel, logistics and supervision system. As for other MOH activities, appropriate training and record keeping will be devised and established for the various levels of the MOH infrastructure, i.e., districts, health post (HP), sub-health post (SHP) and community level.

To initiate this process, assistance will be provided for the selection of districts based on the risk of deficiency and projected impact for a phased implementation plan. Selection will be based on population density, accessibility and available infrastructure, and the potential for developing a practical and flexible timetable for implementing and monitoring capsule distribution. Assistance for baseline assessments to identify simple indicators of vitamin A deficiency will be provided, with priority being given to districts where vitamin A deficiency

diseases are endemic and where dietary factors are known to contribute to reduced vitamin A nutriture. For immediate planning, enough information is available on the factors listed that can be used to select districts. It is anticipated that the need for a national distribution program will be complete within five years, although community-based supplementation will likely be needed for 10-15 years. At the same time, longer term, preventive measures will be taking hold.

For short term measures, the project will work with the MOH/PHD/Nutrition Section and/or the Central Regional Health Directorate to devise annual workplans under which Vitamin A activities will be undertaken. A technical advisor from the long term institutional contractor will provide the bulk of this assistance.

The workplan activities will reflect the general framework for vitamin A interventions as described in the MOH's official statement on vitamin A programming (II.A.4., above). Activities will support materials development, aspects of training, forms preparation and printing, etc. Throughout the country, approximately 5,000 medical and paramedical staff will be trained in vitamin A dosing, supervision, management and record keeping. USAID will support roughly one-third of this training and related local cost. It is anticipated that UNICEF and other donors will fund the bulk of the remaining requirements (training and other), and provide vitamin A capsules for distribution (see HMG-UNICEF Plan of Operations, 1992-1997, ref. No. 14, Annex C).

b) Long term: As a first step, on-going public health services will be modified to enhance the probability of vitamin A deficiency prevention by promoting measles immunizations, deworming services and health education on personal hygiene and sanitation (these factors, if not adequately addressed, contribute to increased risk for vitamin A deficiency through their deteriorating effect on health status). More importantly for long term impact, three main strategies identified as having a positive effect on nutritional status and preventing vitamin A deficiency diseases are adult literacy, nutrition education and home gardening. For any or all of these interventions to have a significant effect, all village members should be included in the target group, with special emphasis on mothers and women.

For enhanced public health services geared toward vitamin A deficiency prevention, the project will work with selected districts within the Central Region to identify sites and means by which these interventions can be productively introduced or strengthened. Initial assistance through the long term technical assistance (TA) contractor will be provided on a small scale pilot basis at the village level and will support careful, step-by-step assessments of the role and ability of workers at this level, i.e., Community Health Volunteers (CHVs), and Village Health Workers (VHWs), to perform required functions correctly in pilot areas. Limited scope sub-contracts with local organizations will be awarded to assist with this process. In all cases, technical consultants will work directly with district and health post

level staff. Expansion will be phased and based on on-going assessments. Sites in 5 districts of the Central Region will have introduced or strengthened services related to vitamin A deficiency prevention.

This project already supports certain aspects of two of the three strategies considered essential for long term impact on vitamin A nutriture, specifically, literacy training and nutrition education activities, both through on-going involvement in the CHV program. The project has already assumed a leading policy dialogue voice with the HMG/MOH and with other donors in support of literacy training. A pilot project in 50 sites of Makwanpur district is already underway, with plans for expansion. HMG/MOH's own statement on support of literacy training as a long term strategy for alleviating vitamin A deficiency (Vitamin A workshop proceedings - see II.A.4., above) will give this project's efforts, as well as those of other donors, an added boost.

Additional assistance will be provided through the long term institutional contractor to help the MOH define its literacy policy in support of preventive health activities; a seminar will be held to disseminate the findings and lessons learned from the pilot literacy program introduction; and expansion will be phased as resources (infrastructure, staff, etc.) permit. Planning for and implementation of expanded literacy activities will build on this umbrella project's already documented experience in the initial 50 sites, and will involve the national level MOH and Ministry of Education and Culture, as well as district and health post staff, at the concerned sites. Literacy activities will be undertaken at 200 additional sites in the Central Region.

Nutrition education is included among the topics discussed at Mothers Groups meetings (Mothers Groups are informal ward-level gatherings of local mothers to discuss topics related to health, sanitation and general well being), led by the respective community's CHVs. The project will support increased production of nutrition education materials for use by the CHVs, based on materials already tested and developed under the University of Michigan Vitamin A Child Survival Project, particularly those materials that relate to vitamin A nutriture.

NGOs in Nepal support a great number of field health service delivery sites which can promote or are already promoting vitamin A deficiency prevention. NGOs have also taken a proactive support of literacy activities. The project will expand innovative and/or priority need literacy activities through NGOs. In addition, NGOs have been active in community and home gardening activities, which this project will also be able to expand. It is also anticipated that NGOs will be active in the conduct of baseline assessments, capsule distribution in respective service areas, monitoring functions and evaluation and feedback on field activities.

Three new NGO activities will be undertaken to support both short and long term interventions as defined in this project description. Priority will be given to NGOs which seek to strengthen the existing public health services by including vitamin A deficiency

prevention interventions (measles immunizations, deworming, etc.), and which initiate literacy, nutrition education and home gardening activities.

3. Coordination, Planning and Implementation

As previously mentioned, an important tool for organizing all elements of the program is the operation of a national coordinating unit to oversee implementation of various agencies' activities and to maintain a link with the National Planning Commission for high level policy support. This project will provide technical assistance, short term training and related support to strengthen the National Nutrition Policy Coordination Committee (NNPCC), and will assist with the establishment of a Technical Coordinating Committee for vitamin A activities in Nepal. Through the long term technical assistance contractor and special TA from centrally funded contracts, the Technical Coordinating Unit will strengthen the NNPCC's ability to give vitamin A technical support to Ministries and NGOs when requested; assist with the standardization of vitamin A protocol, training aids, and promotional material/campaigns; serve as a coordination and communication mechanism between governmental and non-governmental organizations; map vitamin A activities within the country; and support donor input by assisting in prioritizing needs.

C. Expected Results

The intended outcomes include strengthened capabilities of the MOH/PHD/Nutrition Section to implement targeted vitamin A deficiency programs, i.e., ability to establish and implement detailed service delivery procedures for vitamin A capsule distribution under the MOH's integrated, decentralized system; and dissemination of increased knowledge and application of preventive options among health service providers and the public. Refined and improved IE&C messages on good nutrition will be institutionalized. All health care workers involved in service delivery in the project areas, from the ilaka health post level down to CHVs will have been trained in vitamin A-related systems of information collection, supervision and monitoring, and in basic technical aspects of vitamin A nutrition and its relationship to maternal and child health (approximately 5,000 medical and paramedical staff, in 25 districts will be trained). Training will be complemented by up-to-date findings from on-going research. Also, the National Nutrition Policy Coordination Committee (NNPCC) will have been technically and administratively strengthened, and will serve as the national level coordinator for vitamin A activities in Nepal.

These activities are expected to result in a 25% reduction of vitamin A deficiency in project areas. With this result, and based on the findings of extensive research conducted on vitamin A supplementation, this project will have significantly contributed to its goal of reducing child mortality associated with common childhood ailments.

D. Summary of Inputs

Technical assistance for vitamin A activities will consist of support from the major resident institutional contractor, from buy-ins to central projects and, to build in-country institutional capacity, through contracts or agreements with local firms and organizations. The project will support the local costs of training (i.e., training allowance, materials development), and local contracts for training workshops and/or special surveys, as required.

1. Technical assistance: Anticipated assistance from the on-going TA contractor and through buy-ins to centrally funded projects are detailed in Section IV., B.3. and C., below.
2. Training: This project activity has a large training component for basic and refresher trainings, in support of MOH initiatives to provide its staff with requisite skills.
 - a) In-country training: All levels of health workers in the CRHD and other selected districts as identified in yearly workplans will be trained to plan, manage, supervise and/or deliver vitamin A services. It is anticipated that MOH personnel in 6 districts per year will receive one week's training in vitamin A. MOH trainers will conduct the training on a tiered basis (training of trainers, etc.). Total participants are estimated at 5,000 people.
 - b) Out-of-country training: Specialized short term out-of-country training will be provided primarily in subjects related to vitamin A program planning, preventive educational programs, and supervision and evaluation. This category may also include observation/study tours of vitamin A prevention and/or maintenance programs in other countries in the region (15 pm total). It is estimated that 20 people will be trained for 0.75 month each.
 - c) Commodities and Supplies: The project will provide only limited commodities related to vitamin A programming, monitoring and evaluation, e.g., one micro-computer system. The bulk of funds will be used for educational and teaching materials for in-country training (estimated MOH staff in 6 districts/year), literacy classes (200 sites) and Mothers group meetings (19 districts in the Central Region).
 - d) Local cost support (LCS): LCS will cover such training-related costs as facility rental, meetings, selected honoraria, materials development, printing, stationery, etc., as required for the implementation of yearly workplans. LCS needs will be identified on a yearly basis during workplan design and negotiation.

- e) **NGO/PVO Grants and Cooperative Agreements:** This project will continue and/or initiate NGO activities which contribute to the attainment of the project's purposes. Specific examples might include grants to organizations already involved in vitamin A distribution, eye care, home gardening and/or adult literacy, e.g., SCF/USA, CARE, HKI.

E. Financial Plan

The following tables spell out the expected financial requirements for the project amendment. Table I (Project Costs) shows the annual expected requirements for each component, both from AID and from the GON/MOH. Activities will be initiated in year 1, which corresponds with FY 1993. Table II (Local Currency Components) shows that portion of USAID project costs that will require Nepali rupee expenditures.

Financial management of the project will correspond to USAID/Nepal's Mission General Assessment of Mission Financing Policies and Procedures. The GON/MOH will be required to create annual workplans and place all project costs in the development budget "Red Book", both for their own project-related expenses, as well as those USAID budget line items directly channeled through the MOH. These latter items are in-country training and local cost support (including materials and supplies for training, supervision and transport costs, and stationery).

The management of AID costs under the project will follow AID standard regulations and USAID operating policies and procedures. Administrative reservation of funds for specific purposes will be done through Project Implementation Letters (PILs) signed by an authorized signatory of the Project Agreement. Once this reservation of funds is obtained through authorized GON signatures on PILs, all earmarking of these funds will be done through

Project Implementation Orders (PIOs) signed by USAID, within the terms of the Project Agreement. Local cost support, however, will be earmarked through the use of PILs.

Procedures for reimbursing the principal contractor, making releases to the GON/MOH and funding buy-ins to AID/W central projects will be performed as stated in the project paper.

USAID will make direct payments for local NGO grants, evaluations and audits.

TABLE 1
CS/FPS Project Amendment (Vitamin A): USAID and GON/MOH Project Costs
(Shown in \$000's over three years)

Project Component	1st YEAR		2nd YEAR		3rd YEAR		LOP FUNDING		COMBINED
	USAID	GON	USAID	GON	USAID	GON	USAID	GON	TOTAL
I. Technical Assistance									
A. Principal Contractor									
1. Short Term	40	-0-	70	-0-	40	-0-	150	-0-	150
2. Local Conslt. Cont.	15	-0-	25	-0-	10	-0-	50	-0-	50
3. Support Staff	10	-0-	10	-0-	10	-0-	30	-0-	30
B. Buy-ins to R&D Proj.	300	100	100	25	50	10	450	135	585
TA Total	365	100	205	25	110	10	680	135	815
II. Training									
A. Out-of-Country	30	2	35	2	25	2	90	6	96
B. In-Country	100	4	100	4	100	4	300	12	312
Training Total	130	6	135	6	125	6	390	18	408
III. Commodities and Supplies									
A. Teaching/educational materials	15	-0-	20	-0-	10	-0-	45	-0-	45
B. Computer equipment	5	-0-	-0-	-0-	-0-	-0-	5	-0-	5
C. Vitamin A Capsules	-0-	250	-0-	350	-0-	400	-0-	1,000	1,000
Commodity Total	20	250	20	350	10	400	50	1,000	1,050
IV. Local Cost Support									
A. Training related	75	5	75	5	50	4	200	14	214
B. General Supplies	75	20	75	20	50	15	200	55	255
Local Cost Total	150	25	150	25	100	19	400	69	469
V. NGO/PVO Grants/- Cooperative Agreement	250	105	250	75	100	-0-	600	180	780
Sub-Total I-V	915	486	760	481	445	435	2,120	1,402	3,522
VI. Contingency	46	24	38	24	22	22	106	70	176
VII. Inflation	-0-	-0-	122	76	152	146	274	222	496
TOTAL	961*	510	920	581	619	603	2,500*	1,694	4,194

*\$500,000 has already been obligated in ProAg Amendment No.3

17

TABLE II

LOCAL CURRENCY COMPONENTS

<u>CATEGORY</u>	<u>TOTAL</u> <u>U.S.\$</u>
I. Technical Assistance	80,000
II Training	200,000
III Commodities	50,000
IV. Local Cost Support	400,000
V. NGO/PVO Grants/Cooperative Agreements	600,000
VI. Contingency	67,000
VII. Inflation	174,000
<hr/>	
TOTAL	\$1,571,000

IV. IMPLEMENTATION PLAN

A. Implementation Schedule

<u>Activity</u>	<u>Units</u>	<u>Date</u>
1. PP Amendment Approval	USAID Committee	July, 1992
2. Project Authorization Signed; Project Agreement Signed with MOH	DIR, MOH, HFP	Sept. 1992
3. PIL issued	DIR, MOH, HFP	Oct. 1992
4. TA contract amended to include select responsibilities for Vitamin A activities	MOH, PROC	Nov. 1992
5. PIO/Ts for buy-ins prepared	HFP, MOH	Nov. 1992
6. New agreements with NGOs; implementation begins	HFP, MOH, PROC	Dec. 1992 Jan. 1993
7. Coordinating Committee for Vitamin A activities	MOH, HFP & JSI, UNICEF, other donors	Jan. 1993
8. Intervention planning, workplan budget estimates for 1993-94 prepared	MOH, HFP	Feb. 1993
9. Long term interventions planned and budgets prepared	MOH, HFP, other donors	Mar. 1993
10. Workplan prepared	MOH, HFP	June, 1993
11. Pilot long term interventions launched	MOH, HFP, other donors	July, 1993

12. Activities planned, budget estimates for 1994-95 workplan prepared	MOH, HFP	Feb. 1994
13. Workplan prepared	MOH, HFP	June, 1994
14. Evaluation/feedback	MOH, USAID	Sept. 1994
15. Final evaluation	MOH, USAID	April-May, 1995

B. Implementation Management

1. HMG and Counterpart Project Management

The government entity responsible for implementing the activities described in this project amendment will be the Ministry of Health (MOH). Various levels of the MOH structure and functions at each level have already been described in the Project Paper. The Chief of the Public Health Division oversees the Nutrition Section, through which the majority of project activities will be implemented, and which will be responsible for day-to-day implementation. The Secretary, Minister of Health, by virtue of his position, is Vice-Chairman of the National Nutrition Policy Coordination Committee (NNPCC), under which a (Technical) Coordination Committee for vitamin A activities will be housed. NGOs and technical ministries involved in vitamin A programs will be represented under the auspices of the NNPCC.

2. USAID Project Management

The responsibilities for USAID project management continue as stated in the project paper.

3. Technical Assistance Contractor

On-going TA contractor responsibilities have been delineated in the project paper and the contract itself. The TA contract will be amended to include select responsibilities for vitamin A activities.

C. Contracting Modalities

In addition to changes in the on-going TA contract, the activities to be undertaken by this project will be supplemented with approximately 15 person months of specialized short-term consultant services from a number of R&D Bureau cooperative agreements/contracts. An illustrative list includes VITAL, VITAP, and Vitamin A for Health. Assistance will be primarily focused on strengthening the NNPCC's technical oversight of vitamin A activities

and for up-grading in-country vitamin A laboratory assessment capability. Short term local consultancies totalling approximately 20 person months are also anticipated. The HFP Office will prepare scopes of work and PIO/Ts for each buy-in.

Any other procurement actions necessary to the implementation of activities described in this amendment will be according to the guidelines outlined in the project paper, including those actions required for PVO/NGO grants.

D. Monitoring, Evaluation and Audit Plans

1. Monitoring

Primary responsibility for project monitoring by USAID will be with the Office of Health and Family Planning and with the USAID project committee. Project monitoring will be accomplished through site visits and through routine progress reports provided by the MOH counterpart office (Nutrition Section) and implementing agencies. Consultations with MOH, consultant staff, and other donor representatives will also be used as means of monitoring progress.

The annual workplan and budget developed and agreed upon by USAID and the MOH will provide yearly up-dated criteria against which the project's accomplishments and progress will be assessed.

Reports from the MOH and TA contractors will provide by information for measuring progress. The Nutrition Section will be required to prepare trimester progress reports as part of the annual workplan that will be used in reviewing and developing future workplans and budgets. Contractors will prepare quarterly progress reports and trip reports. MOH, NGO and TA contractor reports will contain fiscal information that will be used in financial monitoring.

2. Evaluation

USAID, selected representatives of the national level MOH and the Nutrition Section, and the Public Health Division, will conduct an annual internal project review in the process of negotiating an annual workplan.

A major, external evaluation of vitamin A activities will be performed as part of all project elements after approximately 2 1/2 years of implementation, i.e., spring, 1995. The evaluation will consider progress vis-a-vis established plans and targets set by the national level vitamin A program. Results and issues identified will be used for the design of continued USAID support to this sector if deemed appropriate at the time.

3. Audit

Elements of this project amendment will be subject to the same audit terms as outlined in the project paper.

. ANNEX 1 - AMPLIFIED PROJECT DESCRIPTION

Child Survival/Family Planning Services Project Grant Agreement

Illustrative Financial Plan
(in U.S. \$000)

CATEGORY	USAID LOP	GON LOP	TOTAL LOP
Technical Assistance	7,454	615	8,069
Training	1,407	260	1,667
Commodities/Supplies	4,710	16,703*	21,413
Local Cost Support **	4,344	1,269	5,613
Construction	796	50	846
Evaluations	200	- -	200
Audit	75	- -	75
Inflation	1,285	2,150	3,435
Local NGO/PVO & CA	1,476	180	1,656
Contingency	753	1,246	1,999
TOTAL PROJECT COST	22,500	22,473	44,973

* Includes commodities and supplies provided by other donors.

** Includes support for NGO/PVO grants and Cooperative Agreements.

211

Child Survival/Family Planning Services Project
A.I.D. Project No. 367-0157

Amendment to the
Project Grant Standard Provisions

SECTION B.5. Reports, Accounting Records, Audits, Inspections

(a) The Grantee shall furnish A.I.D. such information and reports relating to the Project and to this Agreement as A.I.D. may reasonably request.

(b) The grantee shall maintain accounting books, records, documents, and other evidence relating to the Project and to this Agreement, adequate to show, without limitation, all costs incurred under the Grant, the receipt and use of goods and services acquired under the Grant, the costs of the Project supplied from other sources, the nature and extent of solicitations of prospective suppliers of goods and services acquired, the basis of award of contracts and orders, and the overall progress of the Project toward completion ("Project Books and Records"). At the Grantee's option, with approval by A.I.D., Project Books and Records shall be maintained, in accordance with one of the following methods: (1) generally accepted accounting principles prevailing in the United States, (2) generally accepted accounting principles prevailing in the country of the Grantee, (3) accounting principles prescribed by the International Accounting Standards Committee (an affiliate of the International Federation of Accountants), or (4) such other accounting principles as the Parties may agree to in writing. Project Books and Records shall be maintained for at least three years after the date of last disbursement by A.I.D.

(c) If \$25,000 or more is disbursed directly to the Grantee in any one calendar year under the Grant, the Grantee, except as the Parties may otherwise agree in writing, shall have financial audits made of the funds disbursed to the Grantee under the Grant in accordance with the following terms:

(1) The Grantee shall select an independent auditor in accordance with the "Guidelines for Financial Audits Contracted by Foreign Recipients" issued by the A.I.D. Inspector General ("Guidelines"), and the audits shall be performed in accordance with the "Guidelines".

(2) An Audit of the funds provided under the Grant shall be conducted for each fiscal year of the Grantee. The audit shall determine whether the receipt and expenditures of the funds provided under the Grant are presented in accordance with generally accepted accounting principles agreed to in Section (b) above and whether the Grantee has complied with the terms of the Agreement. Each audit shall be completed no later than one year after the close of the Grantee's fiscal year.

(d) The Grantee shall submit an audit report to A.I.D. within 30 days after completion of each audit arranged for by the Grantee in accordance with this Section. The A.I.D. Inspector General will review each report to determine whether it complies with the audit requirements of this Agreement. Subject to A.I.D. approval, costs of audits performed in accordance with the terms of this Section may be charged to the Grant. In cases of continued inability or unwillingness to have an audit performed in accordance with the terms of this Section, A.I.D. will consider appropriate sanctions which include suspension of all or a portion of disbursements until the audit is satisfactorily completed or A.I.D. performs its own audit.

(e) The Grantee shall submit to A.I.D., in form and substance satisfactory to A.I.D. a plan by which the Grantee will ensure that funds made available to subrecipients that receive \$25,000 or more in any one calendar year under the Grant are audited in accordance with this Agreement. The plan should describe the methodology to be used by the Grantee to satisfy its audit responsibilities with respect to any subrecipient to which this Section applies. Such audit responsibilities with respect to subrecipients may be satisfied by relying on independent audits of the subrecipients or on appropriate procedures performed by the internal audit or program staff of the Grantee, by expanding the scope of the independent financial audit of the Grantee to encompass testing of subrecipients' accounts, or by a combination of these procedures. The plan should identify the funds made available to subrecipients that will be covered by audits conducted in accordance with other audit provisions that would satisfy the Grantee's audit responsibilities (a non-profit organization organized in the United States is required to arrange for its own audits; a for-profit contractor organized in the United States that has a direct contract with A.I.D. is audited by the cognizant U.S. Government agency; a private voluntary organization organized outside the United States with a direct grant from A.I.D. is required to arrange for its own audits; and a host-country contractor should be audited by the cognizant Grantee contracting agency). The Grantee shall ensure that appropriate corrective actions are taken on the recommendations contained in the subrecipients' audit reports; consider whether subrecipients' audits necessitate adjustment of its own records; and require each subrecipient to permit independent auditors to have access to records and financial statements as necessary.

(f) A.I.D. may, at its discretion, perform the audits required under the Agreement on behalf of the Grantee by utilizing funds under the Grant or other resources available to A.I.D. for this purpose. The Grantee shall afford authorized representatives of A.I.D. the opportunity at all reasonable times to audit or inspect the project, the utilization of goods and services financed by A.I.D., and books, records and other documents relating to the project and the Grant.

26