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AGENCY FOR INTERNATIONAL DEVELOPMENT

Washington, D. C. 20523

PROJECT PAPER

INDIA: Private Voluntary Organizations For Health (PVOH) II (386-0511)

August 28, 1987

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DEPARTMENT OF STATE

AGENCY FOR INTERNATIONAL DEVELOPMENT

WASHINGTON D.C.

PROJECT PAPER

FOR

PRIVATE VOLUNTARY ORGANIZATIONS FOR HEALTH (PVOH) II

PROJECT NUMBER 386-0511

USAID/INDIA

JULY 17, 1987

UNCLASSIFIED

AGENCY FOR INTERNATIONAL DEVELOPMENT

PROJECT DATA SHEET

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

DOCUMENT CODE: 3

2. COUNTRY/ENTITY: INDIA

3. PROJECT NUMBER: 386-0511

4. BUREAU/OFFICE: ASIA/NEAR EAST — 04

5. PROJECT TITLE (maximum 40 characters): PRIVATE VOLUNTARY ORG. FOR HEALTH - II

6. PROJECT ASSISTANCE COMPLETION DATE (PACD): MM 09 DD 30 YY 95

7. ESTIMATED DATE OF OBLIGATION (Under 'B.' below, enter 1, 2, 3, or 4)
A. Initial FY 87 B. Quarter 4 C. Final FY 91

8. COSTS ($000 OR EQUIVALENT $1 = 12.60 Rs)

A. FUNDING SOURCE	FIRST FY B. FX	C. L/C	D. Total	LIFE OF PROJECT E. FX	F. L/C	G. Total
AID Appropriated Total						
(Grant)	( )	(3,500)	(3,500)	(154)	(9,846)	(10,000)
(Loan)	( )	( )	( )	( )	( )	( )
Other U.S. 1.						
Other U.S. 2.						
Host Country	40		40		495	495
Other Donor(s)	98		98		2,915	2,915
TOTALS	138	3,500	3,638	154	13,410	13,410

9. SCHEDULE OF AID FUNDING ($000)

A. APPROPRIATION	B. PRIMARY PURPOSE CODE	C. PRIMARY TECH. CODE 1. Grant	2. Loan	D. OBLIGATIONS TO DATE 1. Grant	2. Loan	E. AMOUNT APPROVED THIS ACTION 1. Grant	2. Loan	F. LIFE OF PROJECT 1. Grant	2. Loan
(1) S	533			0	0	3,500	0	10,000	0
(2)									
(3)									
(4)									
TOTALS				0	0	3,500	0	10,000	0

10. SECONDARY TECHNICAL CODES (maximum 6 codes of 3 positions each): 440, 760

11. SECONDARY PURPOSE CODE

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

A. Code	PVON	TNG	TECH
B. Amount	8,809	308	883

13. PROJECT PURPOSE (maximum 480 characters)

To expand and improve basic and special preventive health, family planning and nutrition services for the poor by utilizing and strengthening the private and voluntary sector.

14. SCHEDULED EVALUATIONS
Interim MM 11 YY 91 — MM YY — MM YY
Final MM 08 YY 95

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

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

APPROVED BY

Signature

Title Controller, USAID, New Delhi Date signed

17. APPROVED BY

Signature ROBERT N. BAKELY

Title DIRECTOR

Date Signed MM 08 DD 28 YY 87

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

AID 1330-4 (8-79)

UNITED STATES AGENCY for INTERNATIONAL DEVELOPMENT

NEW DELHI, INDIA

August 7, 1987

ACTION MEMORANDUM

To: *Mr. Robert N. Bakley - D*

From: *Peter W. Amato - PRJ(A)*

Subject: *Private Voluntary Organizations for Health (PVOH) II - No. 386-0511*

ACTION: You are requested to authorize a $ 10 million grant for the subject project.

DISCUSSION: India has a population of over 770 million people, growing roughly at two percent per year. About eighty percent of the population is rural, living in over 575,000 villages. About 2.5 million children are born each year and there are currently over 100 million children under the age of five. Although children under five account for only fourteen percent of the population, they account for almost half of the total number of deaths annually.

Since 1946, India is committed to improving health care, especially in the rural areas. In 1978, India also became a signatory to the Alma Alta Declaration, committing itself to, "...achieving health for all by the year 2000 AD". In 1982 a revised National Health Policy was adopted in both houses of the Parliament. This was followed by the adoption of a Perspective Plan on Child Development in the year 1984 and a revised Strategy for a National Family Welfare Program in 1986.

The current strategy and programs for implementing the National Health Policy are contained in the 7th Five Year Plan (1985-1990). The Plan has identified six "major thrusts" for the improvement of primary health care throughout the country. The thrust most relevent to the PVOH II Project states that:

"Community participation and people's involvement in the program is of critical importance. Therefore, programs involving active participation of Voluntary Organizations and the mounting of a massive Health Education Movement should be accorded priority."

To assist the Government of India in accomplishing this thrust, AID proposes the PVOH-II Project. PVOH II is a follow-on project which builds on the experience and capabilities of the relatively successful PVOH I Project. The Mid-Term Evaluation of PVOH I, completed in November 1986, provides a number of useful lessons which have been incorporated into the design of the PVOH II Project. In addition, the PVOH I project strengthened the GOI's institutional capacity to respond to the needs of the PVO health service community as a whole; however, that effort is far from complete. The PVOH II project continues this effort and includes financing of: a) approximately 30 subgrants to PVOs to expand and improve basic health, family planning and nutrition services, special preventive health services and training programs with special focus on the rural and urban poor; b) technical assistance to PVOs; and c) costs incurred by the NIHFW in monitoring and evaluating the individual subgrant activities.

FAA Section 612 (b): When the USAID/India program was re-established in 1978, it was determined that project financed local costs could be dollar funded rather than funded from US-owned excess Rupees. PPC reaffirmed views on the matter at the annual CDSS and ABS reviews. In accordance with past practice, your signature on the attached Project Authorization will provide the required FAA Section 612 (b) certification to use foreign exchange to finance local costs under the subject project.

CONGRESSIONAL NOTIFICATION:

A Congressional Notification was forwarded to the Hill on July 23, 1987 and the 15 day waiting period will expire on August 7, 1987.

AUTHORITY

You have the authority to authorize projects for which life-of-project funding does not exceed $20 million. The life-of-project funding of the Private Voluntary Organizations for Health II project is $10 million.

RECOMMENDATION:

That you sign the attached Project Authorization and the Project Data Sheet and thereby authorize a $10 million grant for the Private Voluntary Organizations for Health II Project.

att a/s

Clearences:PRJ:KCKapoor(draft)
HN:EGPHaran(draft)
DPP(A):PThormann (draft)
CO(A):NNWahi (draft)
DD:RNBlue RNBlue

PRJ:RDuda/SBugg:rd:8/7/87/3654C

PROJECT AUTHORIZATION

INDIA

PRIVATE VOLUNTARY ORGANIZATIONS
FOR HEALTH II
PROJECT NUMBER 386-0511

Pursuant to Sections 612 and 104 of the Foreign Assistance Act of 1961, as amended, I hereby authorize the Private Voluntary Organizations for Health II Project (the "Project") for India (the "Cooperating Country"), involving planned obligations of not to exceed Ten Million United States Dollars ($10,000,000) over a five year period from the date of authorization, subject to the availability of funds in accordance with the A.I.D. OYB/allotment process, to help finance the local and foreign currency cost of the Project.

The Project consists of providing assistance to the Cooperating Country to expand and improve the provision of basic health and special preventive health services, family planning services; and nutritional services with an emphasis on expanding such services to rural and urban communities by strengthening the private and voluntary sector.

The Project intends to finance subgrants to a number of Private Voluntary Organizations to support a variety of activities related to the provision of health services to the target beneficiaries. In addition, funds will be utilized to finance the provision of technical assistance to the subgrantees in a number of specific areas related to the implementation of the approved subgrant activities as well as to finance costs incurred by the National Institute of Health and Family Welfare in monitoring and evaluating individual subgrant activities.

The Cooperating Country intends to contribute the Rupee equivalent of an estimated Four Hundred and Ninety Five Thousand U.S. Dollars ($495,000) to finance local currency costs associated with the administration and management of the Project.

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

A. Source and Origin of Goods and Services

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

e

B. Covenants: Except as A.I.D. may otherwise agree in writing, the Grantee will agree to:

Insure that none of the funds made available under this Grant are used to finance any costs relating to (i) the performance of abortion as a method of family planning; (ii) motivation or coercion of any person to undergo abortion; (iii) biomedical research which relates, in whole or in part, to methods of, or the performance of, abortion as a method of family planning; or (iv) active promotion of abortion as a method of family planning.

Approved Robert H. Boyle
Disapproved
Dated August 28, 1987

3674C

INDIA

PRIVATE VOLUNTARY ORGANIZATIONS FOR HEALTH II (386-0511)

Certification Pursuant to Section 611 (e) of
The Foreign Assistance Act of 1961, as Amended

I, Robert N. Bakley, principal officer of the U.S. Agency for International Development in India do hereby certify that in my judgment the Government of India has both the financial capacity and the human resources to carry out, utilize and maintain the project effectively. This judgment is based upon the analysis contained in the Project Paper, as well as the successful maintenance and utilization of projects in India previously financed or assisted by the United States.

Robert N. Bakley
Director, USAID/India

August 28 1987
Date

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LIST OF ACRONYMS AND ABBREVIATIONS

A.I.D.	The United States Agency for International Development
CIDA	The Canadian International Development Agency
CPs	Conditions Precedent to Disbursement
DANIDA	The Danish International Development Agency
DEA	Department of Economic Affairs, Ministry of Finance, GOI
EZE	Evangelishche Zentralstella Fuer Entwicklungshifle (Protestant Central Agency for Development Aid (Germany)
GOI	The Government of India
HC	Host Country Contracts
HN	USAID/New Delhi Office of Health and Nutrition
IDRC	International Development Research Centre (Canadian)
IRHP	Integrated Rural Health & Population Project
IQCs	Indefinite Quantity Contracts
LOP	Life-of-Project
MOHFW	The Ministry of Health and Family Welfare
NGOs	Non-Governmental Agencies
NIHFW	The National Institute of Health and Family Welfare
ORT	Oral Rehydration Therapy
OXFAM	Oxford Famine Relief Organization (U.K.)
PCC	Project Coordinating Committee
PILs	Project Implementation Letters
PVO (s)	Private Voluntary Organization(s)
PVOH I	The Private Voluntary Organizations for Health Project (386-0469)
PVOH II	The Private Voluntary Organizations for Health II Project (386-0511)
Rs.	Rupees (The Indian National Currency)
SIDA	Swedish International Development Agency
SGC	The Special Grants Committee of the MOHFW
SS	Special Secretariat of the SGC
TA	Technical Assistance
TB	Tuberculosis
TOR	Terms of Reference
UIP	The Universal Immunization Program of the GOI
USAID	The U.S. Agency for International Development's Mission to India.

I. PROJECT SUMMARY

A. Project Description

1. Funding: Over the eight year life of the Project the following pattern of contributions will be provided:

USAID contribution	$10,000,000
GOI contribution	$ 495,000*
PVO's contribution	$ 2,915,000**
Total LOP	$13,410,000

2. The Goal: The overall Health Sector goal which the Project relates to is the reduction of morbidity, mortality and fertility among the rural and urban poor Indian population, with a particularly focus on the morbidity and mortality of children under five and women of child bearing age.

3. The Purpose: The Project purpose is to expand and improve basic and special preventive health, family planning and nutritional services for the poor by utilizing and strengthening the private and voluntary sector. The primary target beneficiary group will be rural poor with a focus on women and children. Approximately 30 subgrants will be approved under the Project.

4. Project Components: The Project will finance local currency and limited foreign exchange costs of the following set of components:

Subgrants to PVOs	$11,660,000
Technical Assistance (TA)	$ 465,000
Training	$ 308,000
Subgrant Monitoring & Evaluation	$ 322,000
GOI Management & Administration	$ 495,000
PVOH II Evaluation	$ 160,000***
TOTAL COST	$13,410,000

5. Project Implementation: The Implementing Agency for the PVOH II Project will be the Ministry of Health and Family Welfare (MOHFW). The National Institute of Health and Family Welfare (NIHFW) will play a central role in the appraisal, monitoring and evaluation of the PVO subgrant activities that are to be funded by the Project.

NOTE: * The contribution is to be a local currency cost provided in kind or through GOI salaries of its staff.

** The contribution is to be a local currency cost provided by PVO's towards their share of the subproject cost.

*** The component is composed of a dollar cost of $154,000 and a Rupee cost equal to $6,000.

TA will be made available to both the PVO community and the NIHFW on an as needed basis for a variety of identified short-term requirements. The PVOH II Project will be evaluated, as a whole, at least twice during its eight year life. USAID will participate in appraisal, approval and monitoring of subgrants.

B. ISSUES:

The Project Paper presents the design team's proposals for dealing with a number of anticipated issues, however the experience gained during implementation of the Project will determine how these issues are finally resolved. The following is a summary of some major project issues with suggested responses that the Project managers may wish to utilize or modify during Project implementation.

1. Sustainability of subgrant activities - Sustaining the implementation of subgrant funded activities once the initial Project funding has been utilized, is a major concern. In order to enhance the possibility of sustaining these activities over the long-term, acceptable PVO proposals will be required to:

   - contribute at least twenty five percent of the total subproject costs, in cash or in kind, from any source other than the PVOH II subgrant. Such contributions will exclude the cost of any TA provided under the grant;

   - Estimate annual recurrent, post-grant, costs while identifying how these costs will be financed subsequent to the utilization of the PVOH II grant funds. This must include identification of possible sources of funding and the specific amounts of money that are expected from each source;

   - Preference will be given to funding proposals which contain a relatively higher contribution to recurrent costs and/or propose an increasing rate of PVO contribution to the financing of such recurrent costs over the life of the activity; and

   - Each subgrant will include funds for the contracting of necessary TA to assist the grantee in any aspect of subgrant implementation and management. Such TA may, if appropriate, include assistance in planning a fund raising campaign aimed at securing sources of financing for recurrent costs of the subgrant activities.

2. Financing Plan - This Project will differ from the PVOH I Project in at least one major way i.e. it is a dollar funded project rather than a rupee funded project. As a result, questions related to the flow of project funds were raised during the design process and procedures adapted to the unique requirements of the project were agreed to between the DEA and USAID. The details of the flow of project funds are provided in the "Cost Estimate and Financial Plan" section of the PP. It is anticipated that these adaptations will allow project implementation etc. to move ahead as projected

in the PP. Should problems develop during implementation, additional adaptations and adjustments will be made.

3. Provision of TA - A variety of TA is to be provided to the PVOs and to the NIHFW in order to enhance the design, management, evaluation etc. capabilities of these organizations. The PP outlines a number of possible alternative plans for contracting and providing such TA. During project implementation the most appropriate of these alternatives will be selected and tested. As necessary, the chosen alternative will be adapted/adjusted during the life of the Project.

II. BACKGROUND & RATIONALE

A. Background:

1. The Problem - India has a population is over 770 million people, growing roughly at a rate of two percent per year. About eighty percent of the population is rural, living in over 575,000 villages. About 25 million children are born each year and there are currently over 100 million children under the age of five. More infants die annually in India than in any other country in the world. Between 1975 and 1980, almost one fourth of the world's infant deaths were Indian babies. Over that same period, India had almost three times the number of infant deaths as China, the country with the second highest number.

   Children under five make up only fourteen percent of the population, yet they account for almost half of the total number of deaths annually. The infant mortality rate for India as a whole was estimated in 1982 to be 105 per thousand live births. One third of all deaths are in the under one year age group and, of these, sixty percent occur in the first month of life. For India, the first day, the first month and the first year of life hold great health related risk.

   There are a number of factors that influence these statistics and the Project attempts to have a positive impact on them. Such factors include: a considerable variation in infant mortality between states; a variation between rural and urban areas of the country (morbitity in the target groups is about forty per cent higher in the rural area for the 0 to 4 years age group.); and a variation between the educational level of mothers (analysis of available data indicates that fifty to sixty percent of all deaths of children are due to a small number of preventable diseases and interrelated conditions. Critical among these are maternal nutrition, especially as it affects low birth weight, and infant and child malnutrition.)

   In order to have a positive impact on these factors the Project will focus on direct interventions such as: the immunization of children; the use of Oral Rehydration Therapy (ORT); growth monitoring; improved child nutrition; and a number of other

activities primarily targetted on mothers and pregnant women. Such targetting is essential because children under two, especially those under one, can most effectively be reached through their mothers. In addition, child health is directly linked to maternal health. Therefore, indirect interventions such as: tetanus immunization of women; maternal health and nutrition; child spacing and family planning; and female literacy and non-formal health education at the village level will also have a beneficial, synergistic affect on the maternal/child health aspects of The National Primary Health Care System.

2. India's Commitment and Strategy - India's National Health System and its stated commitment to improved health care, especially for the rural population, extends back at least to the Bhore Committee Report of 1946. The Report outlined the Plan for a National Primary Health Care System providing curative and preventive services through a network extending from district hospitals to comprehensive Primary Health Care Centers to Village Level Subcentres staffed by paramedical workers. The physical aspects of that infrastructure, designed forty years ago, is today largely in place and effective implementation of the Plan offers the prospect of high coverage health services throughout the country.

In 1978, India became a signatory to the Alma Alta Declaration, committing itself to, "... achieving Health for All by the year 2000". In 1982, a revised National Health Policy was adopted in both houses of Parliament followed in 1984 by the adoption of a Prospective Plan on Child Development and in 1986 by a Revised Strategy for a National Family Welfare Programme. The National Health Policy lays considerable emphasis on: the preventive and promotional aspects of health care; greater decentralization of services; self-reliance through greater transfer of skills to and participation by the community; and the development of an effective Primary Health Care System. Specific, quantified, time bound goals for the year 1990 are part of the Policy. They include among others, specific targets for the reduction of the crude birth rate, the infant mortality rate, the prevalence of low birth weight among newborns and the maternal mortality rate.

The current strategy and programs for implementing the National Health Policy are contained in the 7th Five Year Plan, which covers the period 1985-90. The Plan increased the budget for maternal and child health by 255 percent and identified six "major thrusts" for the improvement of primary health care throughout the nation. The thrust most relevant to the PVOH II Project states that:

> Community participation and people's involvement in the Programme is of critical importance. Therefore, Programmes involving active participation of Voluntary Organizations and the mounting of a massive Health Education Movement should be accorded priority."

3. Relationship to the USAID Country Strategy - The Project is an integral part of USAID's 'Child Health and Development Strategy' which was adopted in 1986. The Strategy's overall objective is to effectively support the GOI's effort to reduce infant and child morbidity and Mortality through an 'Integrated Child Survival' approach that can be delivered on a sustained basis. The Strategy provides for a mixed program/project mode that operates at the policy level as well as at the day-to-day level of Project implementation. It is at this grass roots level that the PVOH II Project will operate. The following types of project activities are specifically included in the Strategy when it states that, "...USAID will support activities to:

   "Encourage engagement of other sectors and PVOs in support of the 'Universal Immunization Program' (UIP) of the GOI;

   Encourage engagement of other sectors, PVOs and other institutions in the 'National Oral Rehydration Therapy Program';

   Encourage and support the universal involvement of PVO's and the commercial sector in contraceptive distribution; and

   Focus assistance on PVO support for activities that strengthen and expand the delivery of a package of nutrition and health activities."

4. The PVOH I Project - PVOH II is a follow-on project which builds on the experience and capabilities of a relatively successful PVOH I Project. The Mid-Term Evaluation of PVOH I, completed in November 1986, provides a number of useful lessons which have been incorporated into the design of the PVOH II Project. (The Executive Summary of the Mid-Term Evaluation is provided in Annex G of this PP.)

   PVOH I was authorized in August 1981 as a six year project and an estimated LOP funding level of $26.7 million. AID's contribution of Rs. 167.4 million (then the equivalent of $20 million at Rs. 8.37 = $1.00) was financed by a Special Foreign Currency Appropriation of the U.S. Congress.

   PVOH I went through considerable evolutionary change during implementation including a two year extension of the PACD to September 30, 1989. Originally envisioned as a Project with 10-15 relatively large subgrants, it now has funded 32 approved subgrants which range in size from Rs. 1.2 million to Rs. 17.2 million. Also the subgrant approval process was revised into a three tiered system with differing approval authority for each tier. Under the revised system: The MOHFW can approve subgrants of up to Rs.2.5 million; subgrants of Rs.2.5 to Rs.7.5 million are reviewed and approved by the MOHFW with the optional limited participation of USAID; and subgrants of Rs.7.5 million and above require USAID participation and approval.

Another significant changes in the original Project was a shift in the responsibility for monitoring and evaluation of subgrants from the MOHFW to the NIHFW. The Project now provides for the reimbursement of eligible NIHFW costs, including salaries of a small project monitoring and evaluation unit.

5. Other Donor Assistance to PVOs - Other International Donor Agencies including Canadian (CIDA), Swedish (SIDA) and Danish (DANIDA) agencies are involved in providing funds to PVOs for the health sector activities in India. Although these agencies also operate on a bilateral basis, because the total funding they provide to the PVO community is relatively small, they are able to channel most of their assistance through their own respective Non-Governmental Organizations (NGOs). These NGOs, in turn, operate health programs and projects in India with indigenous organizations. For example, CIDA works through a number of Canadian PVO's and provides funding for hospital construction, public health programs, drug subsidies, transport and salary support. Other Donors to PVO's in the health field include: OXFAM (UK); IDRC (Canada); the Ford Foundation and the Agha Khan Foundation. UNICEF also provides a small amount of funding to indigenous PVO's for the procurement of equipment and vehicles. Most of these funds are not routed through GOI.

   Unfortunately, there is no comprehensive source of data on such assistance to PVOs in India. However, the available data indicates that the total amounts allocated by the International Donor community for PVO activities in the field of Health is fairly small and that individual grants normally range between $50,000 to $300,000. The data also indicates that the vast majority of such assistance to PVO's come from church related overseas donors (e.g. Catholic Relief Service, EZE of Germany, Christian Children Fund, etc.). Most of this assistance is available to sister organization in India and much of it goes to hospital based, curative services and verticle programs such as leprosy care.

   Notwithstanding the fact that such funds are provided to large numbers of PVO's in the health field there is still a large unmet need for assistance to indigenous PVO's (over 400), working in community based Health Outreach Services, that are preventive and promotional in nature. These PVO's do not have a religious affiliation and often are the only source of such outreach services in an areas. (Analysis supporting these conclusion can be found in Annex F.2 Technical Analysis.)

6. GOI Grant Programs - The MOHFW presently administers a number separate Government Grant Programs for PVO's. All of these Programs are specialized and none support the type of community based maternal and child health activities that will be supported by the PVOH II Project. Among others, the present GOI Programs provide grants for:

   - Vertical programs, such as leprosy and TB;
   - Establishing hospitals and dispensaries in rural area;

- The promotion of voluntary blood donations;
- The training of traditional medical practitioners; and
- Specialized family planning services.

B. Rationale for PVOH II:

1. PVOH I - Both the GOI and USAID agree that the PVOH I Project is a successful channel for providing badly needed funds to a segment of the PVO community which innovatively serves the health needs of a target population that might not otherwise receive health services. In addition, there is also agreement that the Project is a mechanism that has strengthened the GOI's institutional capacity to respond to the needs of the PVO health service community as a whole and that this effort is far from complete. Therefore, given the obvious need for additional funding and TA for the PVO community that works in the health service field, the GOI has requested USAID to develop PVOH II as a follow-on Project to the PVOH I Project (refer Annex D).

2. Coordination with other Projects and Programs - The Project funded subgrants will support activities below the district level and will cover estimated target populations of between 30,000 to 100,000 person each. In that these subgrants are to focus on community activities, the majority of coordination with other GOI and NGO health programs will take place at the local level. In addition, the process of subgrant review and appraisal, at the Center, insures that subgrant activities do not duplicate or supplant existing programs or efforts of either the GOI, the NGO community or the International Donors.

III. DETAILED PROJECT DESCRIPTION

A. Life-of Project & Funding Level:

The PVOH II Project provides a total life-of-project (LOP) funding level of $13.39 million (approximately Rs.169 million equivalent at Rs. 12.60 = U.S.$1.00) over an eight year period. USAID's contribution will be a grant of $10 million (approximately Rs.126 million). Individual PVOs will contribute an estimated Rupee equivalent of $2.9 million (approximately Rs.37 million), while the GOI will contribute the Rupee equivalent of $495,000 (approximately Rs. 6.2 million) for the cost of project administration. The eight year life-of-project will allow the GOI to spread the appraisal and approval work load for about 30 subprojects, over the initial three year period and thus allow a five year implementation period for each subgrant. The major components of the Project are subgrants to PVO's, TA and training and monitoring and evaluation. These are described in subsection D below.

B. Goal & Purpose:

1. Goal - The goal of the project is to reduce morbidity and mortality and fertility among rural and urban poor in India, and particularly morbidity and mortality of children under five.

2. Purpose - The purpose of the project is to expand and improve basic and special preventive health, family planning and nutrition services for the poor by utilizing and strengthening the private and voluntary sector.

C. Objectives of the Project:

The objectives of the Project, which are subordinate to the Purpose, are:

- To create PVO sponsored health outreach activities that are self sustaining.

- To support and test innovative approaches to community based health care, family planning and nutrition programs.

- To identify and strengthen institutions capable of providing technical assistance to health PVO's; and to stimulate their use as a resource by the PVO's.

- To foster a system of information exchange among health PVO's.

- To upgrade the skills of core health PVO managerial and technical staffs.

- To improve the quality of community level training for community health workers, volunteers and village women.

- To support special health related activities and preventive programs, such as literacy training for females, sanitation and low cost ways of providing safe drinking water.

- To encourage and support programs to integrate traditional and western systems of health care.

- To support the dissemination and utilization of the most effective treatment methods, such as oral rehydration for diarrhea.

D. U.S. Grant Financed Activities:

The AID grant funds will finance the following sets of activities:

1. Subgrants to PVOs ($ 8.8 million) - These Government managed subgrants are the heart of the project, and by far its major activity. Subgrants will be generally limited in size to Rs. 2 to 6 million. Exceptions will have to be fully justified and approved by both the MOHFW and USAID. Smaller subgrants will require a particularly strong justification, because of the management workload they impose, but a few such grants may be approved for highly innovative subprojects. The limited size range is expected to produce about 30 individual subgrants. To balance the workload, and thus ensure adequate review and appraisal, subgrant approvals and approvals will be spread over the first three years of the

project (6, 12 and 12 per year respectively). The subprojects will have a maximum duration of five years. Experience under PVOH has shown that shorter subprojects do not allow adequate time for organization and start up.

These subgrants will finance programs to provide: basic health, family planning and nutrition services; special preventive health services; and training programs, primarily for paramedical workers & volunteers. Top funding priority will be given to those subprojects which include the development, study and testing of innovative approaches which focus on fertility, morbidity and mortality, i.e. health oriented literacy training of women.

To expand services to the target beneficiaries, subgrants will be limited to PVOs which are planning outreach services which are community oriented and whose plans emphasize both prevention and cure. The primary target group will be rural poor, and more specifically, rural poor mothers and children. Subgrants for services in urban areas will not exceed twenty percent of the subgrant total and will be limited to outreach services in slum areas not adequately served by the present urban curative system.

2. TA and Training ($773,000) - A major component of the Project, that does not exist in the PVOH I Project, is the provision of TA to PVO's. Experience in PVOH I has demonstrated that indigenous PVO's in India, almost universally, lack the necessary skills in one or more technical or managerial areas that are critical to the success of their subprojects. The major conclusion of the Mid-Term Evaluation of PVOH I was that PVO's require assistance in the following: Project design; Design and implementation of baseline surveys; subproject management and simple management information systems; training; communication/health education; and the technical aspects of community health outreach services.

   Professionally competent TA will be made available in the above fields and each subgrant will include funds earmarked to finance such assistance. These services will be supplemented by workshops, training courses and perhaps a PVO newsletter as a means of sharing experiences among subgrantees and imparting technical and managerial know-how.

3. Monitoring & Evaluation ($482,000) - The Project will finance monitoring and evaluation of both the subgrants and the Project, as a whole. An estimated $322,000 will be used to reimburse the NIHFW for the direct and contractual costs of monitoring and evaluating subgrants. The remaining funds, an estimated $160,000 will finance a Mid-Term and an End of Project Evaluation for the overall Project.

E. Project Implementation:

1. Subgrant Activities - The primary focus of the Project and the subgrants under it, will be maternal/child health and family planning in a frame- work of primary health care. Subgrants will

be limited to PVOs which are planning new or expanded outreach service delivery programs in poor and tribal areas that are not adequately served by the health care system. Such programs must be community oriented and should include surveillance for high risk families and individuals; individual counselling through home visits; and community based group promotional and educational activities. Preference will be given to innovative activities and subprojects which emphasize both preventions and cure. Services may be offered by trained villagers, paramedical workers, and medical (including indigenous) practitioners.

a. Basic Health, Family Planning and Nutrition Services - Within the above framework, the Project will finance subgrants to support the following types of activities, either independently or in combination: maternal/child health care; family planning services; nutrition of women and children under five; health education; immunization and ORT; treatment of common infectious diseases such as diarrhea, respiratory diseases, parasitosis, malaria, eye diseases and skin problems; and special preventive dervices. These services must be linked to an essential referral system for maternal/child health, family planning and common emergencies. Family planning services should not be restricted to a single method but rather should offer a cafeteria of alternative contraceptive methods.

b. Training Programs - The Project will support the following types of training programs: training of paramedical workers; training of health management personnel (doctors, project managers, supervisors, etc.); and training of village level workers (dais, community health workers, anganwadi workers, animators, volunteers, etc.).

c. Innovative Approaches to Health Care - The Project will give top priority to funding subprojects which include the development, study and test of innovative approaches in areas such as: Community based activities; distribution of contraceptives; ORT delivery packs; iron supplementation; basic medicine; growth monitoring; and different models of community based delivery system such as village/hamlet level women's groups, use of school teachers, family level volunteers and paid workers.

Innovative subprojects must include specific provisions for measuring the before and after situation in the subproject area in order to evaluate the effectiveness of the approach that is tried and fully document the innovative approach itself. Funds for these two purposes will be included in the subgrant.

d. Integrated Approaches - The Project will support integrated approaches to fertility, morbidity and mortality reduction, such as: Health oriented literacy training and non-formal education of women, especially in the adolescent age group; low cost approaches to chlorination of drinking water and provision of environmental sanitation primarily for education and

demonstration purposes; and Integration of health services with existing development activities such as milk cooperatives, women's organizations and organized labour groups.

2. Activities not Eligible for Project Support:

a. Abortion Related Activities - None of the funds made available under the Project may be used to finance any costs relating to: (1) the performance of abortion as a method of family planning; (2) the motivation or coersion of any person to undergo abortion; (3) biomedical research which relates, in whole or in part, to methods of, or the performance of, abortion as a method of family planning; or (4) active promotion of abortion as a method of family planning.

b. Other Activities - Project funds may not be used to finance the following: Specialized care or the salaries of medical specialists, other than obstetritcs, gynaecology and pediatrics; services for degenerative diseases, such as cancer and diabetes; services for the mentally ill; services for the rehabilitation of the physically and mentally handicapped; dental health care; vertical programs, such as leprosy, TB and eye care, except as part of an integrated program ot primary health care; clinical offices for solo practitioners; and in-hospital (bedded) services, except for emergency obstetrical services and special care services for children 0-5 years of age in support of an expanded, community oriented outreach program.

3. Medicines: All medicine costs in any subproject will be financed as part of the PVO's contribution to the subproject.

4. Construction and Equipment: Construction funds will be provided in subgrants primarily for rural health care facilities, such as rural health centers and village health outposts, and for directly related residential facilities for Paramedicals and other essential staff in a rural setting. Classrooms and demonstration centers may be included provided it is demonstrated that they are essential to the implementation of the subproject and their long-term use and sustainability is evident.

Hospital related construction will be supported in exceptional cases and then only for expansion of outpatient departments, obstetric departments and pediatric departments, when this construction is part of an organized program of expanded Outreach to the community that is essential to the success of such outreach activities. Construction costs will normally not exceed twenty five percent of the total subproject costs.

The financing of equipment and supplies will be limited to essential items up to the limit required in a primary health center. Essential vehicles may be financed for field supervision and mobile health activities but will be limited to two wheel vehicles, jeeps and mobile vans and subject to USAID Source/Origin requirements.

5. Subgrantee Criteria: The subgrantees under the Project will be indigenous, non-profit, PVOs. To be eligible, an applicant institution must meet the following minimum eligibility criteria:

   - Institutions seeking assistance must be registered under the Indian Societies' Registration Act of 1860, or other equivalent statute. (This act provides legal status to cooperative and voluntary agencies and imposes certain obligations on their part such as maintenance of accounts, audits, appointments of boards of directors, etc.);

   - Institutions receiving assistance under this Project maybe of any religion, caste or creed but must be non-sectarian in the provision of health care services;

   - Institutions must have a history of acceptable financial accountability in their operations to date; and

   - Institutions must have had at least three years successful experience in Health Care Delivery, Training, Womens Activities, or other development activities.

6. Subgrant Process: The details of the process of subgrant appraisal and approval are provided in Annex H, Processing of Subgrant Applications. However, a brief summary of that process follows. To begin the process, applicants will submit a relatively short initial application to the special secretariat of MOHFW. These will be screened by the Secretariat for completenss and to determine whether the eligibility criteria are met. The screened applications will then be reviewed jointly by a Project Coordination Committee (PCC) against agreed upon criteria. The PCC membership includes representatives of the MOHFW, the NIHFW and USAID/New Delhi Delhi. Potentially eligible subgrantees will be short-listed and appraisal visits will be made to them by PCC members or their representatives. These visits will further assess potential eligibility, but their major purpose will be to identify subproject design gaps. Where necessary, TA will be provided to short-listed applicants for the final subproject design and the preparation of a final proposal.

   Final Proposals will be reviewed and must be approved by the Secretariat and USAID before submission to the GOI Spcial Grant Committee (SGC) for final approval. All approved subgrants will include a start up period of three to six months. The initial funding released to the subgrantee will cover the costs of a baseline survey, including any required TA; salaries of core subproject staff; and the establishment of an acceptable accounting system. The release of additional funding to the subgrantee will be conditioned on the submission of an acceptable baseline survey.

   Day to day GOI management of the Project will be the responsibility of a Special Secretariat (SS), while responsibility for monitoring, including financial monitoring, and evaluation of the subgrants,

will be delegated to the NIHFW. This Institute has created a Monitoring and Evaluation Unit for this purpose which utilizes faculty members for this purpose.

Project Budget and Financial Plan are as provided in section IV. In brief, except for those project components where AID will make direct payments, all grant expenses will initially be incurred by MOHFW and will be reimbursed by AID based on quarterly requests for reimbursements from MOHFW, through the Ministry of Finance, based on actual expenditure statements of the sub-grantees. Such reimbursement requests will include, in addition to sub-grantee expenditures, expenditures incurred by NIHFW in connection with TA, Training, Monitoring etc. Details of the reimbursement procedures will be spelled out in Project Implementation letters (PILs).

7. PVO Contributions and Sustainability: The PVOH I Project requires that each PVO contribute, in cash or in kind, twenty five percent of the total subproject costs excluding TA and that subgrant applications address the question of post-grant financing of recurrent costs. Despite this, questions related to the sustainability of the subproject activities during the post-grant period remain. Therefore, the PVOH II Project places great emphasis on a review during the appraisal phase of the subproject approval process, on the financial viability of the PVOs and the proposals they submit. The steps to be taken in the Project to help improve sustainability include the following:

- PVO's will be required to contribute twenty five percent of total subproject costs, excluding TA costs, in cash or in kind. This contribution may include overhead costs that are clearly attributable to subproject activities. The contribution need not come from the PVO's internal funds, it can come from any source other than the subgrant.

- In the subgrant applications, PVO's will be required to estimate annual recurrent, post-grant, costs and to specifically identify how they propose to meet these costs. This must include identification of the sources of funding and the specific amounts of money that are expected to come from each source. The adequacy of plans to sustain post-grant activities will be a major criteria in subproject appraisal and approval.

- PVO contributions will be related to the subproject costs as a whole, and not to line items within it. Such contributions need not be equal in every project year, so long as they total to twenty five percent of the total costs over the life of the Project. Preference will be given to funding those proposals which contain a relatively higher contribution to recurrent costs and to those which propose an increasing contribution to recurrent costs over the life of the project. The subgrant financial plan will clearly indicate the PVO share by line item each year.

- The overall financial soundness and sustainability, of each PVO's past performance as an organization and the size of the subproject in relation to its present portfolio of activities will be taken into account in determining the eligibility of the subgrant proposals and the level of subgrant funding to be provided under the PVOH II Project.

- The Project will support TA and/or training for PVO staffs in both subproject management and in fund raising. As noted in the Economic Analysis (Annex F.4) of the PP such improvements in the quality of service provided and the efficiency with which subprojects are managed will enhance the potential for sustainability.

G. Contracting Arrangements

The determination of the most appropriate mode of contracting will be based on actual requirements and on a joint USAID/MOHFW decision. All Technical Assistance (TA) procured under this project will be with Indian organizations or individuals and will require prior USAID approval. The following types of separate contracts are anticipated.

- Contracts by NIHFW: An NIHFW contract or contracts to obtain the services of a panel of experts with specialized skills (community health, management information system, PVO expertise, etc.) to assist in its subproject appraisal and monitoring. NIHFW subcontracts with reputed chartered accountant firms for the task of financial monitoring of subgrantee accounts.

  It will survey the organizations and individuals capable of providing TA and their costs and award contracts. Alternatively, it may also utilize an informal arrangement as explained below. Contracts for chartered accountant firms will be done just the same way as in PVOH I using a competitive procedure.

- Contracting for TA and PVO's: The area of TA would include proposal development, subproject design, baseline survey, management information system, project management, community health, and strategies for raising funds to sustain subgrant activities after the project duration.

  A survey of the organizations and individuals capable of providing the TA required will be conducted. It will include a summary description of their capabilities, experience and cost estimates. The mechanism for contracting for this survey will be worked out jointly by USAID/MOHFW. The Project Coordinating Committee will then prepare a short list/panel of eligible organizations and individuals based on their level of expertise, reasonableness of cost and their willingness. Funds for the procurement of the TA services will be included in the subgrants and the PVO's will contract for their services directly. The Coordinating Committee will prepare a handbook explaining the procedures for contracting these services and how payments and reimbursements are to be

processed. This panel of experts will be periodically updated depending on the type of TA required and satisfactory performance of those of the panel.

- Mid-project and end-of-project evaluations will be contracted by USAID directly as per its standard procedures. It may utilize US and/or Indian organizations and individuals.

NIFHW and PVO's will claim reimbursement from MOHFW which in turn will consolidate these expenditures and claim reimbursement from USAID.

IV. PROJECT BUDGET AND FINANCIAL PLAN

A. General:

The Project will have a total life of project budget of $13.4 million. Of this AID will provide $10 million (74.7%), the GOI will provide the equivalent of $495,000 (3.7%) and the PVO sub-grantees will contribute, in cash and kind, the equivalent of $2.9 million (21.6%).

B. Project Costs:

Table I below is a summary of budget estimates by project component and source. All project costs are local currency costs except for $154,000 provided for project evaluation which is expected to be a dollar cost to be incurred by AID directly.

Of the $10 million AID share of project costs, the equivalent of $8.745 million is for sub-grants to PVO's. It is estimated that this amount will cover approximately 30 sub-grants of $150,000 to $500,000 each. The costs involved in each subgrant will of course not be known until subgrant proposals are received and screened.

Under each approved subgrant MOHFW will initially advance to the sub-grantee an amount equal to approximately 6 months requirements of each sub-grantee. The sub-grantee will submit to MOHFW on a quarterly basis a statement showing (a) opening balance of advance, (b) actual expenditures during that quarter, (c) the balance of advance available, (d) requirements for the next quarter and (e) additional advance requested, which will be (d) minus (c). The MOHFW will pay the sub-grantee the additional advance requested. MOHFW will prepare a consolidated statement of actual expenditures of all the sub-grantees for that quarter and forward it to the Ministry of Finance, Department of Economic Affairs, for claiming reimbursement from AID. AID will arrange this reimbursement in the same manner as it does for all other dollar funded local currency projects.

Among the other project components for AID Financing are technical assistance, training, sub-grant monitoring and evaluation. Technical assistance will be contracted for by individual subgrantees as proposed in Sec. III. Payments made by the subgrantees to the

TABLE I

Summary of Cost Estimates - By Source and Component

($000)*

Component	U.S. Grant LC	U.S. Grant FX	U.S. Grant TOTAL	GOI LC	PVO LC	TOTAL LC	TOTAL FX	Total
Subgrants	8,745	-	8,745	-	2,915	11,660	-	11,660
Technical Assistance	465	-	465	-	-	465	-	465
Training	308	-	308	-	-	308	-	308
Subgrant Monitoring & Evaluation	322	-	322	-	-	322	-	322
Project Management & Administration	-	-	-	495	-	495	-	495
Project Evaluation	6	154	160	-	-	6	154	160
Total	9,846	154	10,000	495	2,915	13,256	154	13,140

*Rs. 12.6 = $1.00

NOTE: Total may not add due to rounding
LC - Local Currency costs
FX - Foreign Exchange costs

contractors will be reimbursed by MOHFW, and, in turn, by AID as described above. Training may be through NIHFW or individual contractors depending on a mechanism to be jointly worked out by USAID and MOHFW with payment and reimbursement provisions as above. Subgrant monitoring and evaluation costs will be incurred by NIHFW. Like the sub-grantees, NIHFW will also receive an advance from MOHFW and submit the same kind of quarterly statements to MOHFW as the sub-grantees. MOHFW will include NIHFW expenditures as a separate item in its consolidated quarterly claim for reimbursement from AID through the Ministry of Finance.

It is estimated that six subgrants will be approved in the first project year (US fiscal year 1988) and 12 each in the second and third project year respectively. Table II below shows projected expenditures under the project components beginning US FY 1988 through

FY 1995. These expenditure projections have necessarily to be somewhat vague and are subject to variations depending on the actual number and size of subgrants approved each year and the rate at which they are implemented. Since USAID reimbursements will be based strictly on sub-grantee and NIHFW expenditures, it is likely that there is no USAID disbursement at all in the first project year.

TABLE II

Estimated Annual Project Costs by Source of Funding and Component
($000)*

Component	U.S. FISCAL YEARS**								
	1988	1989	1990	1991	1992	1993	1994	1995	TOTAL
AID TOTAL									
Subgrants									
1st year grants	175	262	350	350	350	262	-	-	1,749
2nd year grants	-	350	524	700	700	700	524	-	3,498
3rd year grants	-	-	350	524	700	700	700	524	3,498
Subtotal	175	612	1,224	1,574	1,750	1,662	1,224	524	8,745
Technical Assistance	25	126	168	94	52	-	-	-	465
Training	15	40	44	48	53	58	24	26	308
Subtotal	40	166	212	142	105	58	24	26	773
Subgrant monitoring and Evaluation	10	20	30	43	47	52	57	63	322
Project Evaluation	-	-	-	70	-	-	-	90	160
SUBTOTAL AID	225	798	1,466	1,829	1,901	1,772	1,305	704	10,000
GOI TOTAL***									
Project Management & Administration	40	48	53	58	64	70	77	85	495
PVO Contributions									
Subgrants									
1st year grants	58	87	117	117	117	87	-	-	583
2nd year grants	-	117	175	233	233	233	175	-	1,166
3rd year grants	-	-	117	175	233	233	233	175	1,166
TOTAL PVO Contributions	58	204	409	525	583	554	408	175	2,915
GRAND TOTAL	323	1,050	1,927	2,412	2,548	2,396	1,790	963	13,410

* Rs. 12.6 = $1.00

** U.S. fiscal year is from October 1 to September 30. For example, FY 1988 = October 1, 1987 to September 30, 1988.

*** Local costs of GOI project adminsitration converted into $ using the exchange rate of Rs. 12.6 = $1.00

NOTE: Totals may not add due to rounding

Table III is the same expenditure projection as in Table II, recapped by the major project cost components.

TABLE III

Estimated Annual Project Costs by Source of Funding and Component

($000)*

Component	U.S. FISCAL YEARS 1988	1989	1990	1991	1992	1993	1994	1995	TOTAL
Subgrants	233	816	1,632	2,099	2,332	2,215	1,632	700	11,660
Technical Assis- & tance & Training	40	166	212	142	105	58	24	26	773
Monitoring, Manage- ment & Evaluation	50	68	83	171	111	122	134	238	977
TOTAL	323	1,050	1,927	2,412	2,548	2,396	1,790	963	13,410

* Rs. 12.6 = $1.00

NOTE: Totals may not add due to rounding

Table IV below shows methods of Implementation & Financing.

Table IV

METHODS OF IMPLEMENTATION & FINANCING

Method of Implementation	Method of Financing (U.S. $000)	Estimated Cost
Subgrants	HC Reimbursement	8,745
TA	HC Reimbursement	465
Training	HC Reimbursement	308
Subgrant M/E	HC Reimbursement	322
Monitoring Evaluation	Direct USAID	160
Subtotal		10,000
Project Management	HC Contribution	495
Subgrants	PVO Contributions	2,915
Total Project Cost		13,410

C. Audits

The GOI will maintain separate books and records for the grant funds. These shall provide adequate records of the activities financed under the Project relating to the administration, monitoring and evaluation of the Project; the nature and extent of solicitation of prospective suppliers of required goods and services; the basis of award of Host Country (HC) contracts and Work Orders; and overall progress of the Project. These will be available for audit by AID.

Each sub-grantee will be required to maintain a separate, non-interest bearing, bank account and separate books and records for the subproject showing information similar to that described above. The subgrantee's books and records will be audited by a Chartered Accountant employed by the NIHFW immediately after the completion of each project-year. In addition, the sub-grantee's books and records will be available for inspection and audit by both the MOHFW and USAID.

The Project will be implemented by the MOHFW and the NIHFW which are both subject to the contracting, audit, and payment verification procedures and guidelines prescribed by the GOI. As stated in USAID's initial submission of the 'Mission Financing Policy and Procedures as of December 31, 1984',

> "... USAID has reasonable assurance, based on thirty odd years experience, that the Government and its departments have the necessary financial and management capability to implement projects. "

Although USAID has not had any recent reviews, specifically of either the MOHFW's or the NIHFW's payment verification systems and practices, USAID is generally satisfied with their capability to implement projects. In fact, both MOHFW and NIHFW have been involved in the implementation of other AID projects and USAID has had no occasion to doubt their administrative, audit, and/or financial management capabilities. The bulk of the funds under this Project will be disbursed through the MOHFW, a line Ministry of the GOI.. USAID does not feel any special needs for an audit beyond the standard GOI audit coverage and therefore no funds are being earmarked under the Project for that purpose.

V. IMPLEMENTATION PLAN

A. The Administrative Structure:

The Administrative structure of the Project and the definition of the responsibilities and authorities of the organizational elements which comprise that structure are described in detail in Annex F.1 Administrative Analysis. In summary, they are as follows:

1. The Special Grants Committee (SGC) - in the MOHFW will be responsible for the overall direction of the Project and the approval of all subgrants.

2. The Secretariat - (the Voluntary Organization Project Cell) in the MOHFW will provide staff support for the SGC and will be responsible for day to day management and implementation of the Project.

3. The NIHFW - will be responsible for monitoring and evaluating the subgrant activities, directly and/or by contract. The Evaluation Unit of the NIHFW created for this project will be responsible for coordinating and providing staff support for this activity and will draw on other faculty members of the Institute, as needed.

4. The Project Coordinating Committee (PCC) - comprised of representatives of the MOHFW, the NIHFW and USAID will be established by PIL to coordinate project activities and to identify and resolve problems that arise during implementation.

B. The First Six Months of the Project:

Although some pre-implementation actions will take place before October 1 1987, U.S. Fiscal Year (FY) 1988 (October 1, 1987 to September 30, 1988) will be the first year of the Project.

Following the signing of the Project Agreement in August 1987, a six month period will be required for the completion of other legal and administrative actions before the first subgrant applications can be solicited. During this period, the following actions will take place:

- The Project Agreement (Pro Ag) will be signed.

- The Conditions Precedent (CPs) will be met.

- The members of the Project Coordination Committee (PCC) representing USAID, the MOHFW and the NIHFW will be designated.

- Procedures for regular monthly meetings of the PCC will be prepared.

- The MOHFW will prepare an estimate of first year project costs. The estimate will be reviewed and approved by USAID and the approved amount will be advanced to the GOI.

- The MOHFW will establish a separate bank account for Project funds.

- Assisted by the Secretariat, the PCC will prepare a revised set of application forms and an information booklet on the Project and the application requirements and process, for prospective subgrantees. The MOHFW will publish the forms and booklet and arrange to distribute them to potential applicants.

- The MOHFW will initiate action to add at least one Senior Technical Assistant/Investigator to the staff of the Voluntary Organizations Project Cell.

- The NIHFW will initiate action to establish a senior level full-time position to Head the evaluation unit and to create two full time professionals positions.

- The PCC will prepare subgrant appraisal criteria.

- The PCC will issue guidelines for semi-annual progress reporting by subgrantees.

- The NIHFW will contract for the assistance of a panel of Community Health Specialists in subproject appraisal and monitoring.

- Contractors will be identified to provide TA in subproject design and plan preparation and the design and conduct of baseline Surveys (See Contracting Section above.).

- Data collection on the existence and qualification of potential contractors for other types of TA will be started, possibly by use of a contractor to conduct an initial survey.

- The PCC will prepare an initial schedule of meetings or workshops for subgrantee PVO's.

C. The Remainder of the First Project Year:

With a Project Agreement signing in August and four months required to complete the initial six months of the pre-implementation activities, there will be about eight months remaining in the first year of the Project. During this period, the following actions will take place:

- The NIHFW will prepare revised guidelines for monitoring and evaluation reports and will submit them to the Coordinating Committee for review and approval.

- Preliminary applications will be reviewed by the PCC and a short-list of about six applications will be prepared.

- Appraisal visits will be made to the short-listed applicants.

- Revised applications will be submitted by the short-listed applicants.

- The revised applications will be appraised again, if necessary and up to six subgrants will be awarded.

- The MOHFW will advance funds to the approved PVO grantees for the first six months of subproject activity.

- The MOHFW will submit the first reimbursement claim to USAID.

- Either MOHFW or AID will directly contract for the Survey of TA for the PVOs.

- Contractors for providing TA to PVOs will be selected and procedure for contracting developed by the Project Coordination Committee.

D. The Second Project Year (FY 1989):

The second project year will be an iteration of the last eight months of the first year, with three additions:

- The number of subgrant appraisals will increase to 12.

- Monitoring visits will be made to the first six subgrantees.

- One subgrantee meeting or workshop and one subgrantee training course will be held.

E. The Succeeding Project Years (FY 1990-95):

1. Year Three - The third year of the Project will be an iteration of year two, with an additional 12 subgrantees to be monitored. This will be the last year for subgrant appraisal and approval.

2. Year Four - The fourth year will require that the maximum number of subgrants, about 30, will be monitored (30 to 60 monitoring visits). In addition, the original subgrants will be ready for their Mid-Term Evaluation and an overall Mid-Term Evaluation of the Project will also take place in this year.

3. Year Five and Six - there will be 12 Mid-Term Evaluations of the Subprojects during each of years 5 and 6.

4. Final Subproject Evaluations - will be conducted in project years 6, 7, 8 as the subgrants are completed.

5. Final Years - The number of subgrantees to be monitored will decline by six in year 7 and twelve in year 8. The Final Project Evaluation will occur in year eight. Subgrantee Meetings and Workshops will occur in every project-year, with the last Training Course in year 6.

CHART: IMPLEMENTATION SCHEDULE - FIRST YEAR

No.	Activities	Action	Aug.1987 - Sep.1988											
			9	10	11	12	1	2	3	4	5	6	7	8	9
	Grant Agreement Phase														
1.	Signing of grant agreement	USAID	*												
2.	Fulfillment of C.P.'s	GOI	*	*	*										
	Preparatory Phase														
3.	Designation of Project Coordinating Committee Members	PCC	*												
4.	Estimate first year budget and release of funds	MOHFW USAID				*	*								
5.	Establishment of a separate bank Account for the PVOH II Project	MOHFW				*									
6.	Add one senior technical assistant to the Secretariat	PCC								*	*				
7.	Procedure for monthly meeting of the Project Coordinating Committee	PCC	*												
8.	Revise set of application requirements and proposal guidelines into a brochure	PCC		*	*										
9.	Print brochures about the grant for potential applicants	MOHFW				*									
10.	Publicity about the grant program	MOHFW				*	*								
11.	Schedule 1st year workshop and meetings	PCC			*										
12.	First workshop to publicise about the project	MOHFW						*							
13.	Prepare Subgrant appraisal criteria	PCC					*	*	*						
14.	Prepare guidelines for semi-annual/ quarterly reports by the Subgrantees, Ministry and the National Institute	PCC					*	*	*						
15.	Appoint a senior level full time Head for the Monitoring Cell and recruit other staff	NIHFW	*	*	*										

No.	Activities	Action	Sep.1987-Sept.1988												
			9	10	11	12	1	2	3	4	5	6	7	8	9
16.	Prepare revised guidelines for monitoring and evaluation reports	NIHFW		*	*	*									
17.	Review and approval of the revised guidelines for monitoring and evaluation reports	PCC					*								
	<u>Contracting for Technical Assistance</u>														
18.	Identify and contract panel community health and PVO specialists in subproject appraisal and monitoring	NIHFW/ PCC			*	*	*								
19.	Data Collection on the existence and qualification of potential contractors for other types of TA to subgrantees	MOHFW/ USAID					*	*	*						
20.	Develop procedure for contracting for above TA	MOHFW/ USAID									*	*	*		
21.	Identification and selection of TA panel	PCC									*	*	*		
	<u>Processing of Applications for Subgrants</u>														
22.	Receipt of first set of applications	MOHFW						*	*	*					
23.	Review and shortlisting for appraisal	PCC							*	*					
24.	Field appraisal visits	Joint								*	*	*			
25.	Submission of revised proposals	MOHFW										*	*		
26.	Review of revised proposals	PCC												*	
27.	Approval of first set of subprojects	Grants Committe													*

CHART: IMPLEMENTATION SCHEDULE - 2ND YEAR TO 8TH YEAR

No.	Activities	Action	Project Years(FY)						
			89	90	91	92	93	94	95
1.	No. of additional subprojects to be reviewed, appraised and approved	PCC/ MOHFWW	12	12					
2.	No. of subprojects to be monitored	NIHFW	6	18	30	30	30	24	12
3.	No. of workshops and training courses to be held	NIHFW/ PCC	2	2	2	2	2	2	2
4.	No. of midterm evaluations of subprojects	NIHFW/ Contractors			6	12	12		
5.	Overall mid-term evaluatiosn of the project (PVOH II)	USAID			1				
6.	No. of final evaluations of subprojects	NIHFW/ Contractors					6	12	12
7.	Overall final evaluation of the project	USAID							1
8.	Technical Assistance to subprojects - (continuous)	PCC	*	*	*	*	*	*	*

VI. MONITORING PLAN

A. USAID Project Monitoring and Management:

The primary USAID management and monitoring responsibility will be vested in the Office of Health Services (HPN/HS), specifically in the PVOH I/PVOH II Project Officer. The Project Officer will be assisted by the Mission PVOH Project Committee and other members of the USAID staff, who will, as necessary, participate in appraisal and monitoring visits to the subproject sites. Project monitoring will include the following:

- Participation in the subgrant appraisal and approval process, including review of applications and supporting documents and pre-appraisal or appraisal visits to subgrant applicants. As a result of this participation, the Project Officer will be knowledgeable about the concept and design of each subproject.

- Field visits to subgrantees, either individually or a part of one of the NIHFW's monitoring teams. These visits will be infrequent during the first three project-years, when new applications are being appraised and the PVOH I Project is coming to an end. The visits will become more frequent in the fourth year and beyond, as the PVOH II Project moves into full implementation.

- Review of reports of the monitoring visits to each subgrantee by the staff of the NIHFW.

- Review of the semi-annual progress reports that will be submitted by each subgrantee to the MOHFW, with copies to USAID. These Progress reports will show physical progress against planned targets, salient accomplishments and problems, if any, with actions taken or planned to resolve them. Each report will also include forecast of actions to be taken during the next six months and the actions that were forecast for the reporting period and the status of each of them. These semi-annual reports will be submitted within 30 days of the end of each six month period.

- Review of MOHFW's semi-annual project status reports to be submitted to USAID.

- Review of the mid-term evaluation of each subgrant conducted by the NIHFW.

- Review and possibly participation in, the mid-term evaluation of the PVOH II project.

- Membership on the PCC.

- Participation in the annual subgrantee meetings or workshops.

- Periodic contact with TA contractors.

- Review of annual Cost Estimates and quarterly Reimbursement Claims from the MOHFW.

B. Subgrant Monitoring:

Primary responsibility for monitoring the individual subgrants will be vested in the NIHFW. It will be responsible for conducting an on site monitoring visit of two to three days to each subgrantee annually. The visiting team will review overall subproject progress against the project plan and will identify problems which need to be resolved. Financial monitoring will be provided by a team member drawn from a Chartered Accounting firm under contract to the NIHFW. These firms will also provide TA to subgrantees on accounting practices and procedures. The current PVOH guidelines for the monitoring visits and reports will be revised by the NIHFW during the first year of the project. The revision will be directed at improving the narrative content and the quantification of subproject progress reports; identifying, in agreement with the PVO, significant problems, including any required outside TA; and providing for a summary of conclusions and recommendations in each monitoring report.

The NIHFW has established a special unit to monitor PVOH I subgrants. The Unit currently has a staff of seven professionals and routinely draws on other faculty members of the Institute to participate in monitoring visits. The Unit is equipped with a micro computer. Under the Project, the NIHFW will agree to undertake to strengthen this Unit by appointing a senior-level full-time Head and by adding two full-time professionals with expertise in community health, health education and training. In addition, the NIHFW will augment its monitoring teams through contracting with outside TA when necessary (e.g. when the management information System of a subproject appears to be a major implementation problem). The staff should be retained long enough in the Unit to take advantage of the experiences gained and not transferred to other departments during the life of the project.

VII. CONDITIONS AND COVENANTS

A. Conditions Precedent to Disbursement:

Prior to the first disbursement under the Grant or to the issuance by A.I.D. of documentation pursuant to which disbursement will be made, the Grantee 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. Legal Opinion - An opinion of counsel acceptable to A.I.D. that the Agreement has been fully authorized and/or ratified by, and executed on behalf of the Grantee, and that it constitutes a valid [illegible] gation of the Grantee in accordance with

2. Representatives - A statement of the name of the person holding or acting in the office of the Grantee specified in the Project Agreement, and of any additional representatives, together with a specimen signature of each person specified in such statement.

B. Covenants:

Except as A.I.D. may otherwise agree in writing, the Grantee will agree to:

1. Abortion - Insure that none of the funds made available under this Grant are used to finance any costs relating to (a) the performance of abortion as a method of family planning; (b) motivation or coersion of any person to undergo abortion; (c) biomedical research which relates, in whole or in part, to methods of, or the performance of, abortion as a method of family planning; or (d) active promotion of abortion as a method of family planning.

2. Establish financial procedures - which ensure that reimbursements to each subgrantees for expenditures incurred, and any necessary adjustments to the amount advanced to each subgrantee, will be sufficient to provide the subgrantee with an advance equivalent to the subgrantee's estimated expenditures for the six months period following the date of reimbursement.

3. Establish MOHFW position - for at least one Senior Technical Assistant/Investigator in the Voluntary Organizations Projects Cell in the MOHFW.

4. Establish NIHFW positions - i) for a senior-level full-time position of Head of the Evaluation Unit; and (ii) for two full time professionals with expertise in community health, health education and training.

5. Establish a Project Coordinating Committee, which will meet monthly to provide regular oversight and coordination of project activities. The Committee will be comprised of the Under Secretary of the MOHFW (Chairman), the Head of the Evaluation Unit of the NIHFW and the USAID Project Officer for the Project.

6. Insure that the Special Grants Committee and the Voluntary Organizations Project Cell of the MOHFW will continue to function during the life of this Project.

7. MOHFW will insure that adequate funds are budgeted to initiate activities and meet the projected level of expenditure. Since this project is expected to be signed in August 1987, i.e. midway during GOI current budget year, MOHFW should take necessary action to budget funds needed to finance advances to the sub-grantees and the NIHFW.

VIII. SUMMARY OF ANALYSIS

A. Technical Analysis:

The Technical Analysis of the Project is based on the Technical Analysis for the PVOH I Project, plus implementation experience to date. That original Technical Analysis drew on extensive field visits over an 18 month period by Mission staff to PVO's working in the health field. It concluded that the PVOH I Project was technically sound, even though health PVO's tended to be institution based and curative oriented. Experience under PVOH I has proven that conclusion to be correct. Under PVOH I, subgrantee PVO's are successfully mounting community based health outreach programs which include an emphasis on prevention. (Although it is not noted in Annex F-1, the Mid-Term Evaluation of the PVOH I Project noted several technical areas where subgrantees generally need outside assistance. The PVOH II Project will provide such assistance.)

The Technical Analysis also recognizes the substantial potential contribution of traditional health practitioners, if they can be incorporated into subprojects.

B. Financial Analysis:

Both the Technical Analysis and the Social Soundness Analysis of the Project review the structure and capabilities of PVO's in the Health Sector. The conclusions of these analysis is that there is a great potential for PVOs to expand and extend their capacity to provide basic health services, and family planning and nutrition services especially in the rural areas of the country. PVO's appear to have a relatively unique capability is the provision of such services at the community level.

It is this unique capability that forms the crux of the Financial Analysis of the PVOH II Project. The Project will tap this potential by financing community based curative and preventive basic health services, family planning and nutrition services, with a focus on women and children under the age of five. The GOI and USAID feel that the PVOs are an appropriate alternative means of providing such services because:

- They are part of the Private Sector, which provides about sixty percent of the rural health care in India;
- They are geographically dispersed throughout the nation;
- They can reach areas which are unserved or under served by the existing Primary Health Care system;
- They are popular and trusted by rural people due to a reputation for continuity of care;
- They are aware of local needs and social obstacles to the provision of services;

- They are effective in promoting community participation;
- Strengthening the PVOs through PVOH II subgrants will improve the quality and efficiency of any existing services;
- They are willing to innovate;
- They can attract private resources for rural health care; and
- They are recognized by the GOI as an essential element of the overall system of Health Care.

The most obvious alternative to the provision of financial support envisioned under the PVOH II Project is to directly support an extension of the existing GOI's Primary Health Care System. Such an alternative would, in any case, not have the same impact as the PVOH II Project in that it would limit USAID support to some selected geographic area of concentration. This would be essential from the logistics and management point of view. Also such an alternative project methodology would preclude A.I.D. from becoming involved in the wide range of innovative health services that are now being proposed under the PVOH II Project.

Notwithstanding the above, the Project Design Team concluded that a Least-Cost Analysis comparing these two possible alternative projects would not be feasible in that the raw financial and health beneficiary data is not available in any meaningful sense. In fact the PVOH II is attempting to address this absences of reliable data by requiring each subgrantee to develop a baseline survey prior to implementation of the subproject. These surveys will be updated as the subactivities progress and by completion should provide some reliable figures and data on PVO provision of basic health service etc.

Although a Least-Cost Analysis is not feasible, the Project Design Team did intuitively feel that PVO's appear to be an extremely Cost Effective means of providing rural health care because; they attract outside resources; their salaries and overhead costs are relative low when compared to the more traditional means of providing such services; they are prone to innovate in the provision of such services; and they attract significant number of dedicated volunteers and community level participation.

C. Economic Analysis:

The Economic Analysis, Annex F.4, for the Project concludes that a traditional Cost/Benefit Analysis would not be appropriate in this particular project because the necessary a priori assumptions would be so tenuous as to make the analysis fundamentally unreliable.

The Economic Analysis does however provide an indication of the economic rationale for the PVOH II Project. Such a rationale notes that a Net Positive Income Streams with Rates of Return above the Opportunity Cost of Capital may be generated from health investments

in Human Capital (e.g. increased earnings attributable to improved health) and therefore to the extent that the subprojects are experimental or innovative in their approach and subsequently replicated, the discounted investment in Human Capital and the Cost Savings in the provision of health services attributable to the subprojects, may also be added to the Income Stream.

The paucity of data to measure Cost Effectiveness of PVOH II is noted and as indicated above, the Project is making efforts to develop appropriate data and information on the provision of Basic Health Services.

The Economic Analysis also notes the importance of subproject sustainability. This issue is discussed in Section I. B.1 above.

D. Social Soundness Analysis:

The Social Soundness Analysis is based on a comprehensive analysis done for the Integrated Rural Health Project (386-0468). The experience under that project, the PVOH I Project (386-0469), the Integrated Child Development Services Project (386-0504) and other relevant experience has tested and proven the cultural acceptability of rural health, family planning and nutrition projects in India which are centered on the existing primary health care system. PVOH I has also demonstrated the social soundness of community based health services.

E. Administrative Analysis: The Administrative Analysis details the administrative structures that have been established under the PVOH I Project and that will continue to operate under this project. The Analysis concludes that these structures and the relationships among them are sound, although a few additional staff need to be added in the MOHFW and the NIHFW in order to insure that the additional administration and management responsibilities inherent in another PVOH Project will not overwhelm the existing structures. In addition, the Project has provided for some contract TA to both the PVOs and the NIHFW as required during project implementation.

IX. EVALUATION ARRANGEMENTS

A. Overall Project Evaluation:

Two independent evaluations of the Project will be conducted; a mid-term evaluation during the third or fourth year of the Project and a final project evaluation in the last year of the Project (FY 1995). In order to estimate the cost of these Evaluations the Project Design Team provided that they will be carried out by a three person team, working for four weeks each, under a direct A.I.D. contract. The actual composition of the teams and their Terms of Reference will be worked out in consultation with the GOI, but a likely team composition might be: A community health specialist (Team Leader); a finance/management specialist; and a PVO specialist.

1. The AID Mid-Term Evaluation - will assess progress toward the achievement of project objectives and ascertain whether implementation is on track. Constraints to the achievement of project objectives will be identified and mid-course corrections will be recommended.

2. The Final Project Evaluation - will assess the impact of the Project at the Goal and Purpose level. Where progress has fallen short, the Evaluation will assess the reasons for the shortfall. It will also identify problems of project design and implementation and possible corrective measures for use in any similar future projects. Finally, the Evaluation will recommend any identified needs for GOI or donor support for health PVO's in the future, with the financial implications clearly spelled out.

B. Evaluation of Subgrants:

Each subgrant will be formally evaluated twice, once at its midpoint and once when the subproject is completed. The objectives of these evaluations will be essentially the same as those of the overall Project evaluations. These subproject evaluations will be the responsibility of the NIHFW, which will conduct them either directly or by contract. Terms of reference and report formats for the mid-term and final evaluations of subgrants will be prepared by the NIHFW during the second and fifth years of the Project, respectively. They will be submitted to the PCC for review and approval before they are published.

X. PROJECT DESIGN TEAM:

E.G.P. Haran, HN
S. J. Freundlich, PRJ
N. N. Wahi, CO
S. Silberstein, HN
P. Thormann, PRO
P. Amato, PRJ
B. Thomas, ISTI (IQC)

XI. MISSION REVIEW COMMITTEE:

R. Blue, DD
C. Crowley, PRO
G. Thompson, PRJ
G. Eidet, CO
R. Beasley, HN

ADMINISTRATIVE ARRANGEMENTS

The administrative arrangements for processing/approving applications, and monitoring/evaluating the subgrants are already in place. This system with some strengthening, will be adequate to effectively manage the Project. These arrangements are explained in the following sections.

A. USAID Administrative Arrangements: USAID/India's Directorate of Health, Population and Nutrition will have primary responsibility for project administration, assisted by other USAID offices as required. One staff member will be designated USAID Project Officer and made responsible for liaison with the Ministry of Health and Family Welfare. Resident USAID staff (U.S. and Indian professionals) with skills in various specialities will assist the Project Officer perform USAID's role in subproject appraisal, approval, monitoring, and evaluation.

A Project Committee will be established to provide overall policy direction and guidance to the project. However, the Committee's clearance will not be required on new subgrant approvals, disbursements, waivers or other routine implementation matters.

USAID's approval will be required for all subgrants, and it will participate in appraisal and approval of subgrant proposals as explained in Annex H. Routine subproject financial and program monitoring is expected to be performed by the NIHFW. However, USAID will continue to monitor project activities, on a selective basis. As far as possible, USAID staff will join the NIHFW during their monitoring visits.

B. GOI Administrative Arrangements:

The overall body responsible for the Project will be the Special Grants Committee (SGC), which was established under PVOH I. The SGC will be the approving body for all subgrant awards; have overall monitoring and evaluation responsibility; and have overall financial responsibility for Project funds. The SGC will be assisted by a Secretariat (the Voluntary Organizations Project Cell), an administrative body within the MOHFW.

1. Special Grants Committee - The Committee will review and approve all subgrant awards, discuss the progress reports on each subgrantee prepared by the Secretariat and take action when required; and plan and supervise project and subgrant evaluation. The SGC is comprised of the following members:

(i)	Joint Secretary, Voluntary Organizations Project, MOHFW	Chairman
(ii)	Joint Secretary (Financial Advisor) MOHFW, or his nominee	Member

(iii) Director General of Health Services, MOHFW, or his nominee	Member
(iv) Joint Secretary, Department of Economic Affairs, or his nominee	Member
(v) Joint Secretary, Ministry of Human Resources Development or his nominee	Member
(vi) Under Secretary, Voluntary Organizations Project, MOHFW	Member/Secretary

In addition, the Secretary of Health of the concerned state or his nominee and the Director of the NIHFW's Evaluation Unit will be special invitees when appropriate.

2. The Secretariat - A Secretariat (the PVOs Cell) has been constituted under the SGC to handle the routine administration of the Project. An Under Secretary serves as the Head of the Secretariat. It has a few administrative staff. The Secretariat will invite appropriate technical experts from the various departments of the MOHFW to assist it in its work.

   In order to be able to appraise and manage a large number of subgrants more quickly and effectively, the Secretariat staff should have expertise in community or public health; personnel or manpower planning; budgets and book-keeping; and report drafting. Staff should be retained long enough in the Secretariat to take advantage of experience gained in reviewing grant applications. At a minimum, one full-time senior level technical assistant/ investigator will be added to the Secretariat.

   The main duties of the Secretariat are: wide dissemination of information about the grant program; preliminary screening of all applications against eligibility criteria, appraisal of proposals; supervision to ensure adequate monitoring of subprojects by NIHFW; arranging for TA and training for subgrantees; disbursement of funds to subgrantees; and the proper implementation of subprojects.

C. Administrative Arrangements with the National Institute:

The NIHFW, under an arrangement with the SGC will have the principle responsibilities of: Program monitoring of subprojects; Financial monitoring of subprojects; Facilitating TA both in proposal development and in subproject implementation; Coordinating Mid-Term and Final Project Evaluation of each subprojects through local institutions; and Assisting the Secretariat in technical review and appraisal of proposals.

1. Subgrant Monitoring - The NIHFW will monitor the progress of subgrantee activities to ensure the fulfillment of project objectives and the appraised subproject plan. Program monitoring will be done based on information obtained through: semi-annual progress reports of the subgrantees; Pre-implementation visits during the first three months of the subproject to provide guidance on reporting requirements. Subsequent well planned, site visits at least once a year to each subgrantee. The NIHFW will involve local experts with specific skills as part of its monitoring visits; and Special repeat visits to subgrantees with special problems or as follow-up visits where specific recommendations have been made.

2. Financial Monitoring - The NIHFW will do the financial monitoring and annual verification of subgrantee accounts. The principal objective is to ensure that the subgrantee utilizes grant funds in accordance with the approved budget and within the requirements of the Pro. Ag. and the PILs.

   The task of financial monitoring of subgrantee accounts will be done by the NIHFW through subcontracts with reputed Chartered Accounting firms. The selected Chartered Accounting firms will be requested to depute a Chartered Accountant who will visit the voluntary organization, soon after the approval of the subgrant, to review and provide TA to each subgrantee on how it should account for the funds provided under the subgrant. This will involve: Instructions to subgrantees on what records are to be maintained and how; Review of subgrantee's internal controls and procedures relating to cash management, bank reconciliation, procurement of goods and services, stores maintenance, inventory controls, etc. When these controls and procedures are found deficient, advise subgrantees or what actions are to be taken; Advise to subgrantees on how reimbursement claims are to be prepared and how supporting documentation is to be maintained for verification; and Explaining to subgrantees how periodic reports are to be prepared and how records are to be maintained for verification.

   After the initial visit covering the above items, the Chartered Accountant deputed by the firm will make periodic visits, at least once a year, to each subgrantee, as a part of the monitoring team from the NIHFW, to review and verify whether the subgrantee: Maintains adequate records; Maintains internal controls; Prepares reimbursement claims properly; Prepares reports accurately; and Complies with USAID procurement requirements.

   The report of the Chartered Accountant will be a part of monitoring reports to be submitted by the NIHFW to USAID and the Secretariat.

3. Evaluation of Subprojects - Each subproject will be evaluated twice; a Mid-Term Evaluation and a Final Evaluation. The NIHFW will do these evaluations directly, or have them done through subcontracts with local institutions, with the NIHFW playing an

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overall coordinating role. Once the local institutions are identified, there will be a preliminary meeting to design the evaluation Terms of Reference. The subgrantees concerned will be involved in the evaluation process so that information collected is useful to grantees to assess progress, identifying problem areas and to make necessary corrections.

d. Assist the Secretariat in Appraisal - The NIHFW will assist the Secretariat in review and appraisal of proposals. As part of the appraisal team, it will also assist the Secretariat in writing the appraisal reports. If required, the NIHFW may also utilize outside local experts in its review and appraisal activities.

e. Staffing of the Evaluation Unit - The NIHFW has established a Coordinating Group and a full-time Evaluation Unit for the Project. The Coordinating Group consists of senior faculty members of the Institute with expertise in community health communication and training, health administration, and statistics/demography. This Coordinating Group helps and guides the work of the Evaluation Unit. The Evaluation Unit will be managed by a full-time Head. The Unit will have four to six middle level research officers (technical) and necessary secretarial/clerical support staff. Collectively, the staff should have expertise in the following areas: project design and proposal writing, monitoring and evaluation, community health, training and communication, survey designing/statistics/demography, project management and data processing with the use of a micro-computer. Prior experience in working with PVOs will be a special consideration in selection of replacements or candidates for new positions. The NIHFW's capability in appraisal, monitoring and identifying of TA/training needs of subgrantees will be strengthened through a contract panel of local experts with expertise in project design, management information systems, community health and training and communications.

D. Conclusion - The existing structures will be strengthened with additional staff and a panel of experts. These administrative arrangements will be adequate to effectively manage the Project.

TECHNICAL ANALYSIS

A. Previous Analysis: The PP for the PVOH I Project contained a detailed Technical Analysis that is essentially still valid for the PVOH II Project. That analysis stated, in part, that:

> "Voluntary Organizations and private practitioners represent a major asset in India for the promotion of health, nutrition and family planning awareness and services."

In 1974, there were estimated to be over 400 NGOs engaged in health and family planning activities. [The number has certainly increased since then.] Hospitals in the voluntary sector are by and large found in towns and cities, and are mostly run by Christian missions. Although these are found all over the country, they are concentrated in the South where christian missionary activity has been the strongest over the years. Most of these hospitals have some sort of rural extension outreach program, primarily for curative services. There are also hospitals, dispensaries and clinics set up by philanthropic trusts and foundations, and these are also predominantly found in urban and semi-urban areas. They tend to be uni-purpose, (e.g., maternity hospitals), are often limited in their geographical area of operation, and have few rural extension programs, except for occasional eye and immunization camps. Voluntary organizations provide about fifty of small town and rural hospital beds.

Over 2,000 family planning centers are being operated by NGOs. Most of these clinics are located in large cities and towns and cater primarily to the urban population. At present, only a few have rural outreach programs of any kind, or are engaged in family planning promotion or motivation.

In the 18 months prior to the PVOH I Project, Mission's professional staff made extensive field trips to voluntary organizations and discussed their activities and concerns. These visits revealed the following about voluntary organizations: (1) they had begun to develop from conventional hospital or clinic-oriented programs toward an interest in public health and preventive programs, community services, and outreach programs for the poor; (2) they infrequently offered oral contraceptives, condoms, diaphragms, jellies, planned motivation campaigns, or community-based distribution of contraceptives, but many were interested in doing so; (3) they infrequently offered children, village-based health services using paramedical staff, health or nutrition education programs, or environmental improvement campaigns, although many were prepared to do so; (4) they infrequently used oral rehydration salts or growth charts; (5) they were interested in innovative activities but lacked funds to try new activities even though they have impressive field experience; (6) the quality of servies they offered was generally good. Based on these findings, the Mission concluded that there was a great potential for voluntary organizations to expand their basic health, family planning and nutrition services or special preventive programs to greatly enhance public health and fertility reduction in India.

B. The PVOH I Experience - Experience under the PVOH I Project has confirmed the findings above and the belief that expansion of PVO outreach activities, that the PVOH II Project supports, can be achieved. As examples, in the PVOH I PP:

- Most subprojects are targeted at the high risk group of mothers and children.

- All subprojects provide some form of outreach using paramedical and/or village volunteer staff.

- Most are multi-purpose projects, and all subprojects under PVOH II will be multipurpose.

- Several are testing truly innovative approaches to rural health, and this will be encouraged further in PVOH II.

- Most include some form of health or nutrition education, but the quality of the training needs to be improved.

- Almost all involve oral rehydration therapy, although it is more widely accepted among lower level workers than physicians.

- Many include growth monitoring charts, but they are infrequently used as a basis for intervention feeding for the critical cases they identify.

The overall conclusion of the PP design team is that there continues to be a great potential for PVOs to expand and extend their basic health, family planning and nutrition services, especially in the rural areas. The PVOH II Project will tap this potential and will address the continuing technical problems through better subproject design and the provision of TA.

C. Indigenous Practitioners - In addition to voluntary organizations, there are now about 120,000 practitioners of Allopathic medicine in the private sector (mostly in urban and semi-urban areas) and over 600,000 private practitioners following indigenous systems of medicine (Ayurveds, Unani, Homeopaths, Naturopaths, and Siddha), who mostly practice in the rural areas. Some indigenous practitioners are formally trained in an institution, registered by the GOI and usually practice full-time. Others are trained informally by preceptors, not registered by the GOI, practice part-time and usually charge minimal fees. Both types of these practitioners use some forms of Allopathic medicine (e.g. immunization),and together they constitute a large reservoir of untapped potential for improving basic health, nutrition and family-planning services. Some estimates are that, in small towns and rural areas, the government-sponsored system provides about twenty percent of non-hospital services, the organized voluntary sector twenty percent, and private sector (Allopathic plus traditional) about sixty percent.

PVO's should be better able than the GOI to tap this vast reservoir of indigenous practitioners and a few PVOH I subprojects are already attempting to do so. But more needs to be done. The PVOH II Project will give high priority to subprojects which propose to test an approach to rural health outreach that includes both indigenous and allopathic medicine.

SOCIAL SOUNDNESS ANALYSIS

Fundamental social soundness of the primary health care system which the PVOH II subprojects will emulate and extend, or integrate into, is not an issue. The comprehensive social soundness analysis for the Mission's recently compeleted Integrated Rural Health Project (IRHP) concluded that: "It can be said that the [Indian] delivery system of health care and family planning services as presently designed and in operation is consistent with prevailing norms and practices and that we see no serious obstacles to the ability of the proposed project to provide effective health care and family planning services in rural India." Experience under the IRHP, PVOH and Integrated Child Development Services projects has confirmed this judgement. While social constraints, such as the limited participation of women, must be taken into account in the planning and design of project activities, they are not insurmountable.

The private and voluntary health sector plays an important role in meeting the medical needs of rural and urban communities. Rural health behaviour surveys have shown that a majority of sickness care services and expenditures are in the private and voluntary health sector. This tends to hold true for the poor as well as the middle and upper classes. Private and voluntary health organizations have a number of strengths which have made them popular and perhaps more importantly, trusted. These strengths include:

- Their small size, which renders them manageable and flexible in response to experience and local conditions;

- Their awareness of local felt needs and social obstacles. They have substantial knowledge and experience in dealing with the existing social structure of individuals and groups;

- Their sustained contact with the community they serve and the resulting reputation for continuity of care (workers are not subject to frequent transfers); and

- Their means to promote community participation, not only their ability to recruit appropriate personnel more readily, but also their ability to experiment with programs which make modest demands (organizational, financial, work activity, etc.) on the community as a prerequisite to activity. They are in a position to foster community responsibility.

Cultural acceptability of rural health, family planning, and nutrition extension outreach projects in the private and voluntary sector has been tested and proven in numerous instances in rural India in addition to the PVOH Project. Examples include the Jamkhed project in Maharashtra, Child in Need Institute in West Bengal, Tamil Nadu's Gandhigram Institute of Rural Health and Family Welfare, the Ludhiana (Punjab) Christian Medical College Community Health Project, and so forth. The GOI has encouraged these organizations in the past and is interested in their findings. In fact, there is no sense of competition or overlap between these two sectors, since the needs are so great.

PVOH has also demonstrated the social soundness of community based health services which is the hallmark of most of its subgrants. As one example, one subproject has proven that it can successfully recruit and train village mothers to serve as health facilitators and promoters with a small group of neighbours, and that they can be rotated every six months to spread the knowledge imparted by the training.

ECONOMIC ANALYSIS

A. Investment in Human Capital:

The PVOH II Project is not readily amenable to standard economic Cost/Benefit analysis which would treat health services as an investment in human capital, i.e. in particular, estimates of without and with project net income streams. A priori assumptions vis a vis accessability of services, nature and cost of services to be provided, discounted lifetime income streams of individuals covered by services, etc. would be so tenuous as to make analysis fundamentally unreliable as guide to investment.

B. Investment in Innovative Activities:

PVOs have been recognized by the GOI in the Seventh Five Year Plan, 1985-1990 particularly for the important role they play in providing a basis for innovation with new models and approaches ensuring feedback and securing the involvement of poor families that would otherwise not be reached by health service programs. Several innovative models are being tested under the PVOH I Project. In this regard, another perspective from which to undertake economic analysis of the PVOH II Project is as an experimental activity aimed at increasing effectiveness and quality of outreach programs. New approaches (including some that may result in cost savings) from specific subprojects that are widely replicated would set up a stream of benefits from which in theory at least financial and economic rates of return could be developed. However, estimates of the extent of such replication at this time would be highly speculative, and actual data or firm estimates will not be available until after the Project is completed. Nonetheless, in assessing subprojects one of the criteria that will be weighed is the innovativeness of the model proposed by the PVO.

C. Cost Effectiveness:

Aggregate and field level data for center and state level public sector programs on average unit costs of various types of health services are not readily available. Similarly, private sector costs are also not readily available. The Mission was engaged last year in a small research activity to, among other items, pindown at the state level budget allocations to ORT and the expanded program of immunization. The effort went awry because of complexity of tracking expenditures and reluctance of the center to have USAID delve into state/center health budget processes and data. Two years earlier USAID undertook an exploratory review of health finance literature and data and found a virtual absence of literature. disaggregated data and researchers working in the field of health finance. The purpose of the preceding is to note that even at a relatively superficial level quantitative responses to the straightforward question of what is the cost per unit of health service provided at levels of aggregation ranging from the center to the state to the district and to the clinic is not waiting to be pulled off the shelf. Developing this

type of information is a long-term process which will require the development of a network of persons committed to understanding health finance perspective. In this regard, we would note that USAID is planning a small activity for FY 87 that would be a start toward developing such a network.

With regard to issue of costs per unit of services provided beneficiaries under PVOH II, ex ante USAID is not in a position to provide a comparison with existing programs because subprojects to be funded are unknown. In proposals submitted for individual subprojects, USAID will review cost per beneficiary for various services to be offered and take the review into account in appraising individual subprojects. However, comparability issues relating to quality, extensiveness and intensity of packages of services provided, geographic variations, etc. leave USAID less than sanguine about feasibility of developing meaningful comparisons of alternatives.

D. Sustainability:

The issue of sustainability is an exceptionally difficult and major issue with respect to PVOH II. Given the primary focus of the Project on outreach to rural poor, financially self sustaining services based on user charges cannot be anticipated. Hence, sustainability will rest largely on management efficiency and fund raising capability of the PVOs. To the extent the resources provided under the Project are focussed on staff development and training for improving quality and efficiency with which existing programs are managed, the additional recurrent cost taken on by the PVO may not be large and possibly may even result in some decrease in recurrent cost. However, to the extent the resources provided enable PVOs to move into new areas providing new services an additional recurrent cost burden will have to be shouldered.

ANNEX G

PVOH I MID-TERM EVALUATION: EXECUTIVE SUMMARY

A. Background:

After a long history of bilateral assistance to the Government of India in support of primary health care and family welfare activities, AID initiated the Private Voluntary Organizations for Health (PVOH) Project in order to expand and improve both basic health care services and special preventive services in India by developing the underutilized potential of nongovernment organizations and private medical practitioners. Through strengthening the private and voluntary sector, the project seeks to reduce morbidity, mortality, and fertility. Originally funded in 1981, by the time of the evaluation there were 22 projects spread throughout India providing community-based primary health care and family welfare services. The project document provides support for up to 30 PVOs[1], but it has become clear over the duration of this project that there are many more PVOs capable of expanding their activities and there is clearly a demand for services which they are providing.

The PVOH project represents the joint effort of the the Government of India, U.S. Government and private voluntary organizations working in health and population in several ways. First it represents the consensus among these three groups that PVOs can and should play an expanded role in improving health services. Secondly, financial support for these activities comes both from AID and from the subprojects themselves. They are "co-financed" in the sense that AID provides 75% of the total budget and the remaining 25% is raised by the PVOs themselves as a matching contribution. Funds are used to expand and improve the quality of services by hiring additional field workers, providing training, technical and management assistance and improving physical facilities. USAID committed $20 million in August, 1981 from a special foreign currency appropriation which amounted to Rs.167.4 million. The original period of disbursement was six years, but the Project Assistance Completion Date has recently been extended for two years i.e., up to September 1989.

B. Purpose and Methodology:

The overall objective of the Mid Project Evaluation is to assess the progress towards attainment of the goal and objectives of the project as specified in the PVOH Project Paper, the Grant Agreement, and the Implementation Letters and to make recommendations for further improvement of the project. The Mid Project Evaluation focusses on the following three broad areas: a) assessment of subproject implementation activities, b) assessment of the adequacy and effectiveness of administrative, monitoring and technical assistance aspects and c) documentation of the lessons learned and their implications for future directions of this project and/or additional inputs on a bilateral agreement. The fieldwork for this review was conducted from the 22nd of September, 1986 to the 25th of October, 1986. This was followed by further discussions with the officials of the Government of India and USAID. The findings were presented to the NIHFW and the Government of India officials on October 30, 1986 and to the USAID officials on October 31, 1986.

C. Evaluation Findings:

1. The PVOH Project provides an effective structure for appraising and approving subgrants to voluntary agencies and an efficient approval process is now in place. Despite initial delays in the appraisal and approval procedures these have been streamlined over the last five years and in the process some aspects of the original design have been modified to make the project more effective. A very positive collaborative relationship has been developed between USAID, MOHFW and NIHFW after a long organizational period in the the early years of the project.

2. The PVOH Project is an appropriate mechanism for supporting private voluntary organizations in providing primary health care and special preventive health services.

3. The project design includes a number of elements which are increasingly recognized as important by the Government of India and USAID, including (a) the need to strengthen the role of the private voluntary organizations in the delivery of basic health services, particularly in under-served areas, (b) a strong emphasis on community-based PHC outreach services, (c) a stress on key PHC interventions for the reduction of infant mortality, including immunization, ORT, maternal and child health, nutrition, and family planning as well as on promotion of an integrated approach to the delivery of these services, and (d) emphasis on a high risk approach to providing services.

4. The project has assisted in the establishment of a new support cell in the MOHFW for administering this grants program and a new unit in the NIHFW with responsibility for providing technical support, monitoring and evaluation of PVOH subgrantee activities.

5. This has helped to bring into focus the need for systematic monitoring and evaluation of other government programmes like area projects and to recognize the need to further strengthen NIHFW's technical assistance capabilities.

6. The project avoided duplication of public sector services through full participation of government officials in an assessment of the relationship between PVO services and existing government primary health services.

7. The subprojects funded by this project are providing a wide range of primary health care services to a growing number of people. Technical assistance currently being provided will contribute to improved collection of statistics which will document in a quantitative way the contribution of these projects.

8. On the basis of site visits to seven subprojects, it is clear that after an organizational phase many projects have initiated outreach and/or delivery of basic child survival services to needy segments of the population.

9. The problem of financial sustainability of subprojects at the end of the grant period has been identified as a key issue to be addressed.

D. Recommendations & Needs for the Future:

1. As the number of subprojects grow and as the volume of services provided by the individual organizations increases, it is crucial that proposal guidelines be simplified, that technical assistance is provided at the state of proposal development, and that the review and approval process is streamlined.

2. There is a need for substantially increasing technical assistance and training to the subprojects. While NIHFW should continue to play an important role, alternative mechanism of providing technical assistance should be explored and instituted. The possibilities of establishing a network of appropriate regional institutions, panels of local technical experts and regional training workshops should be considered.

3. As the role of the special unit within NIHFW expands with the growth of the project and the need for improving data collection, ways should be explored to provide additional inputs to this unit. The NIHFW's technical assistance needs further strengthening. Particularly, their programme monitoring should be improved so as to make it more supportive of the subprojects, in their day-to-day operations. For implementing this role effectively, external technical support could be obtained.

4. The successful role of the chartered accountants in monitoring and providing assistance on budgetary and accounting matters should be expanded. More frequent visits focussed on training in financial management as well as monitoring of accounts should be planned.

5. The upcoming mid term evaluation of subprojects by NIHFW should be planned with the participation of the PVOs themselves and should focus on ways in which service delivery can be improved after completion of the evaluation. A workshop should be organized with the PVO to discuss evaluation results.

6. Communication among PVOH subprojects and sharing of experiences should be encouraged and financially supported. Organization of workshops and perhaps a monthly or quarterly newsletter should be encouraged.

7. The establishment of quarterly review meetings between MOHFW, NIHFW and USAID should be regularized. These meetings will provide the opportunity for dialogue among the three groups, indepth reviews of progress during the quarter, discussions of problems and identification of technical assistance needs. Issues such as high priority projects to be funded, modifications in financial arrangements, etc. as well as the overall direction and success of the project should be discussed.

8. Experience gained by USAID, MOHFW and NIHFW in the implementation of the PVOH Project should be utilized in responding to the demand which has already been generated for new subprojects. Development of a follow-on project should be seriously considered.

ANNEX H

PROCESSING OF SUBGRANT APPLICATIONS

A. Application Brochure:

During the first six months of the Project, the Project Coordinating Committee will develop a brochure which will include the following elements:

1. Grant description;
2. Institutional eligibility criteria;
3. Selection criteria;
4. Application procedure;
5. A sample application format;
6. Supporting documents required;
7. Guidelines for developing a proposal; and
8. Draft letter of understanding (Bond) to be signed by the applicant.

B. Publicity about the Grant Program and Scouting for Proposals:

One of the Secretariat's first duties will be to develop special program announcements regarding the availability of funds under the grant, using appropriate channels such as leading national and state news papers (multi-lingual), professional periodicals, newsletters of PVO-networks, announcements to state governments, and leading PVO network/umbrella organizations and associations. If necessary, the Government will organize one or two national/regional one-day workshops for key representatives of state governments and PVO communities. The announcements are to insure the widest possible dissemination of information about the program and will be repeated periodically, as necessary.

C. Subgrant Applications:

Interested PVO's will develop a proposal and complete an application to be submitted in triplicate. This proposal will briefly describe the institution's current activities, the goal and purposes of the proposed project, proposed activities, and a budget summary. Essentially, it will be a preliminary proposal and follow the outline required for the final proposal (outline given in Section F). The documents to be included are:

- A two page application giving basic information about the applicant;
- A project proposal;
- A certified copy of the Certificate of Registration;
- The names and addresses of the offices of the governing body/trustees/Board; and
- The last two years' annual reports and audited statements of accounts.

Three sets of the completed application will be sent to the Secretariat.

D. Selection and Short-listing of Viable Proposal:

When proposals are received, the Secretariat Staff will screen the proposals against the established institutional eligibility criteria. Those meeting the eligibility criteria will be selected for technical review by the Coordinating Committee. The Committee will meet at least once every three months to select and shortlist the reviewed proposals for field appraisal during the next quarter. The review committee may also include one or two outside experts to assist in the technical review of proposals.

E. Selection Criteria:

The main criteria for selection of proposals are:

- Subgrant project proposals must supplement or complement existing Government plans and activities in health, population and nutrition.

- Subgrant project proposals must be consistent with the goals and purposes as stated in the Grant description.

- Subgrant project proposals must have clearly stated goals, purposes, and outputs; the methods to achieve them must be technically, administratively, financially, and socially sound; the implementation plan must be reasonable; and an evaluation plan must be included.

- Subgrant project proposals must describe how expanded and improved services will be sustained in the post-grant period;

- Subgrant project proposals must include at least a 25% contribution from the applicant;

- Subgrant project proposals must include the outline of a proposal baseline survey.

- Subgrant project proposals planning to expand services into less well-served areas will be given preference over those planning to expand where services are better served.

- Innovative projects and those which include training, health education, participation of women, non-formal education of women or other promotional activities will be given preference.

Proposals meeting the selection criteria will be further shortlisted and rank ordered based on the proposal's technical soundness, innovativeness, neediness of the target area to be served and the institution's previous experience in the proposed activities.

Quarterly, Project Coordinating Committee will prepare a schedule of joint appraisal visits for the next three months giving priority to proposals with a high rank order (i.e. in the order of merit). The Secretariat will inform the subgrantee organizations of the schedule.

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F. Appraisal Visits:

The joint appraisal team will consist of representatives of the Ministry, the National Institute, USAID and, if necessary local outside experts. The purposes of the field appraisal are:

- To assess the technical managerial and financial capabilities of the organization to implement and sustain the proposed activities;

- To determine the need for the project and appropriateness of the proposal;

- To assess the feasibility and technical and financial viability of the proposal; and

- To determine the technical assistance needs for designing a revised project proposal and a baseline survey.

A joint appraisal report will be prepared by the team soon after the appraisal visit. The report will address the issues listed above and make recommendations for unconditional approval, conditional approval or rejection. Those organizations whose proposals were not rejected will be given two months time to submit a detailed (final) project proposal which will include an initial six-month preparatory phase for conducting a baseline survey, recruiting staff and establishing a management system. Local technical experts will be made available for preparing the final project proposal.

The detailed proposal will include the following information:

- Organization's background and its present activities:

- Goals and purposes of the proposed project;

- Expected output at the end of project;

- A detailed description of project activities including; identification of the target area and its population; the size of the health, nutrition and family planning problem in the area; existing service facilities in the target area; Proposed service activities; Proposed educational activities and Innovative schemes, if any.

- An implementation plan for the project's duration, with a year to year phasing of activities and targets to be achieved.

- How the proposed activities supplement or compliment existing Government plans and activities in health, nutrition and population.

- How the project will be staffed, managed, monitored and evaluated.

- How the PVO will meet 25 percent of the project costs.

- How the activities initiated under the project will be sustained once the grant ceases.

- A budget summary.

- Annexes on resource requirements (buildings, equipment, staff, venicles, transportation and other recurring costs).

During its quarterly reviews, the coordinating commitee will have a final review of the revised proposals. The committee's comments along with the revised proposal will be submitted to the Special Grants Committee for its review and approval. Those proposals which are recommended for rejection will not be put before the Grants Committee.

All subgrants will require the approval of the USAID Project Officer. If there are disagreements between the Ministry and USAID on funding a proposal, these will be resolved to the mutual satisfaction of both parties before submission to the Special Grants Committee.

The Special Grants Commitee will meet at reasonable intervals to consider proposals recommended for its approval and authorize subgrants for proposals which it approves. Institutions whose applicants/proposals are recommended for rejection will be informed by the Secretariat.