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EXTERNAL ASSISTANCE TO THE HEALTH SECTOR AND ITS CONTRIBUTIONS: PROBLEMS AND PROGNOSIS

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Foreword

This paper formed part of a series of background papers prepared for the ICRIER India Health Study, "Changing the Indian Health System: Current Issues, Future Directions" by Rajiv L. Misra, Rachel Chatterjee, and Sujatha Rao. The India Health Study, prepared under the team leadership of Rajiv Misra, former Health Secretary, Government of India, was funded by the Bill and Melinda Gates Foundation.

In the past three decades, India has received considerable external assistance for the health sector. This paper by Professor Devendra B. Gupta, Senior Consultant, National Council of Applied Economic Research, New Delhi and Dr Anil Gumber, Senior Fellow, Warwick Business School, University of Warwick, UK and Senior Economist, National Council of Applied Economic Research, New Delhi, documents the externally funded programmes, projects, and activities in the health sector in India. The paper examines the extent of utilisation of the external funds in this sector and provides a brief description of the problems associated with the externally funded projects. The paper also indicates the role of donors in reshaping health policies and in improving domestic resource mobilisation for the health sector in the country.

Continuing external assistance for the health sector in India will largely depend on the efficient utilisation of funds as well as on its capacity to absorb increased donor funding. Professor Devendra B. Gupta and Dr Anil Gumber have utilised their long experience in this field to provide valuable insights into the role and utilisation of external assistance for the health sector in India.

Shankar Acharya
Acting Director & Chief Executive
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List of Abbreviations

ADB	Asian Development Bank
AIDS	Acquired Immune Deficiency Syndrome
AP	Andhra Pradesh
ASCI	Administrative Staff College of India
CHC	Community Health Centre
CSSM	Child Survival and Safe Motherhood
DAC	Development Assistance Committee
DANIDA	Danish Agency for Development Assistance
DFID	Department for International Development
EOC	Emergency Obstetric Care
EPI	Expanded Programme of Immunisation
ESCAP	Economic and Social Commission for Asia and the Pacific
EU	European Union
FAO	Food and Agriculture Organization
FF	Ford Foundation
FW	Family Welfare
GOG	Government of Gujarat
GOI	Government of India
GoWB	Government of West Bengal
HNP	Health, Nutrition and Population
HP	Himachal Pradesh
ICDS	Integrated Child Development Services
ICR	Implementation Completion Reports
IDA	International Development Assistance
IEC	Information, Education and Communication
IFAD	International Fund for Agricultural Development
ILO	International Labour Organization
IPP	India Population Project
KFW	German Development Bank
LSHTM	London School of Hygiene & Tropical Medicine
MCH	maternal and child health
MIES	Management Information and Evaluation Systems
M&E	Monitoring & Evaluation
MP	Madhya Pradesh
NFHS	National Family Health Survey
NGO	non-governmental organisation
NORAD	Norwegian Agency for Development Cooperation
NTCP	National Tuberculosis Control Programme
ODA	Overseas Development Administration
OECD	Organisation for Economic Co-operation and Development
ORT	Oral Rehydration Therapy
PHC	Primary Health Centre
PM	Project Management
PPI	Pulse Polio Immunisation programme

RCH	Reproductive and Child Health Care
RNTP	revised National Tuberculosis Programme
SHS	State Health System
SIDA	Swedish International Development Agency
STD	sexually transmitted diseases
SWOT	strengths, weaknesses, opportunities and threats
TB	Tuberculosis
TINP	Tamil Nadu Integrated Nutrition Programme
TN	Tamil Nadu
UIP	Universal Immunisation Programme
UK	United Kingdom
UN	United Nations
UNDCP	United Nations Drug Control Programme
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific & Cultural Organization
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commission for Refugees
UNICEF	United Nations Children's Fund
UNIDO	United Nations Industrial Development Organization
UP	Uttar Pradesh
US	United States
USAID	United States Agency for International Development
WFP	World Food Programme
WHO	World Health Organization
WMO	World Meteorological Office

External Assistance to the Health Sector and its Contributions

I

In the past 30 years, India has received considerable external assistance for the health sector, including for family welfare. The extent of this support to the health sector is likely to increase further as is evident from the continuing interest of traditional fund providers comprising of various multilateral agencies and bilateral donors, as well as some of the new donors such as the European Union. However, this support will largely depend on the efficient utilisation of the funds as well as on the capacity of recipient states to absorb increased donor funding.

If we analyse the utilisation of external assistance, we observe certain disturbing trends. Apart from the time lags in the sanction, start up, and disbursement of donor funds, the implementation is reported to be tardy. This has resulted in both time and cost overruns. Some attempts have been made to overcome these problems. One such significant measure relates to improving the flow of funds mechanism through the formation of societies at the state and district levels.

In this paper, an attempt is made to document the externally funded programmes, projects, activities, with general specifications (e.g. funding levels, timeframe, geographical coverage) to the extent possible as determined by the availability of information which is largely fragmented; and appropriate description of key activities and objectives. The paper then provides an idea about the extent of utilisation of funds over the project cycle with the help of a few selected externally funded projects. This is followed with a brief description of the problems associated with the externally funded projects. In doing so, we have relied mainly on the authors' exposure to various key donors and Union/state governments while working on some of the recent projects in the area of health and reproductive health, including nutrition programmes. The paper concludes with summarising the main issues emerging from the analysis, as well as

indicating key lessons for improving the flow of external assistance in the health sector in India. This concluding section, inter alia, indicates the role of donors in reshaping health policies and in improving domestic resource mobilisation for the health sector in the country.

II

Level of External Assistance to Health Sector

External assistance for health generally amounts to a small portion of the total expenditures in most developing countries. But it can constitute a significant part of the investment budget (as well as a large portion of the total health budget), and it plays an important catalytic role in health policy reform. In this section, we analyse the trends in the levels of external assistance. In order to carry out this exercise we rely on several scattered sources of information. Since the scope and coverage of each source varies considerably, what we have done thus is to try to build a story around the main trends. In addition, we have also provided a more detailed description about a few donors, about whom we were able to obtain somewhat more detailed information.

Level of Total External Assistance to India

Before analysing the trends in the level of external assistance to the health sector, it may be useful to provide an idea about the overall total external assistance to India. Tables 1 and 2 provide the necessary data. It is seen that the quantum of external assistance to India showed a rising trend in the initial period, reaching its peak in 1988–89, and then a plateau (Chart 1). There was a sudden drop in external assistance during 1998–99, presumably because of the donor community's reaction to India's nuclear blast. Most external assistance during this period and later has related to humanitarian and emergency assistance, besides continuance of some assistance already committed to the social sector. Further, a large proportion of external assistance has come in the form of loans. It would now be interesting to see the record of utilisation of external assistance. Chart 2 provides an idea about the gap in authorisation of total external assistance and its

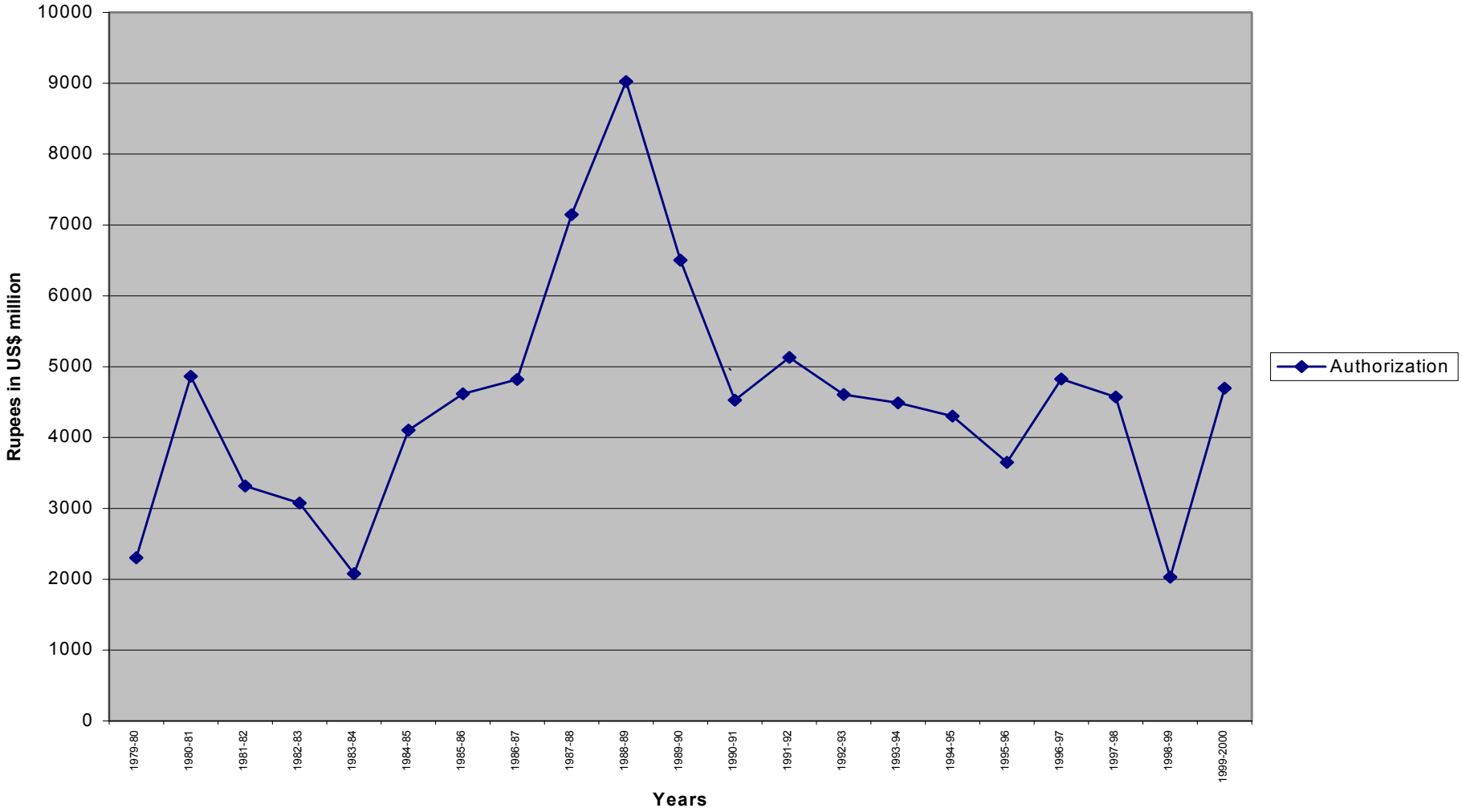
utilisation. Except 1998–99, the utilisation has by and large lagged behind the authorisation. As will be seen later in the paper, this pattern is also indicated in regard to external funds obtained for the health sector.

Table 1: Overall External Assistance (Authorization)
(US $ million)

	Loans	Grants	Total
1979-80	1604	699	2303
1980-81	4769	96	4865
1981-82	3085	231	3316
1982-83	2638	438	3075
1983-84	1645	374	2019
1984-85	3709	396	4105
1985-86	4362	256	4618
1986-87	4484	336	4820
1987-88	6327	819	7146
1988-89	8877	148	9025
1989-90	6070	433	6503
1990-91	4326	291	4527
1991-92	4766	364	5130
1992-93	4276	331	4606
1993-94	3718	773	4490
1994-95	3958	344	4302
1995-96	3250	399	3649
1996-97	4000	826	4826
1997-98	4007	566	4573
1998-99	1979	50	2029
1999-00	4091	904	4696

Source: Government of India, Economic Survey 2000-2001.

Chart 1: Overall External Assistance (Authorization)



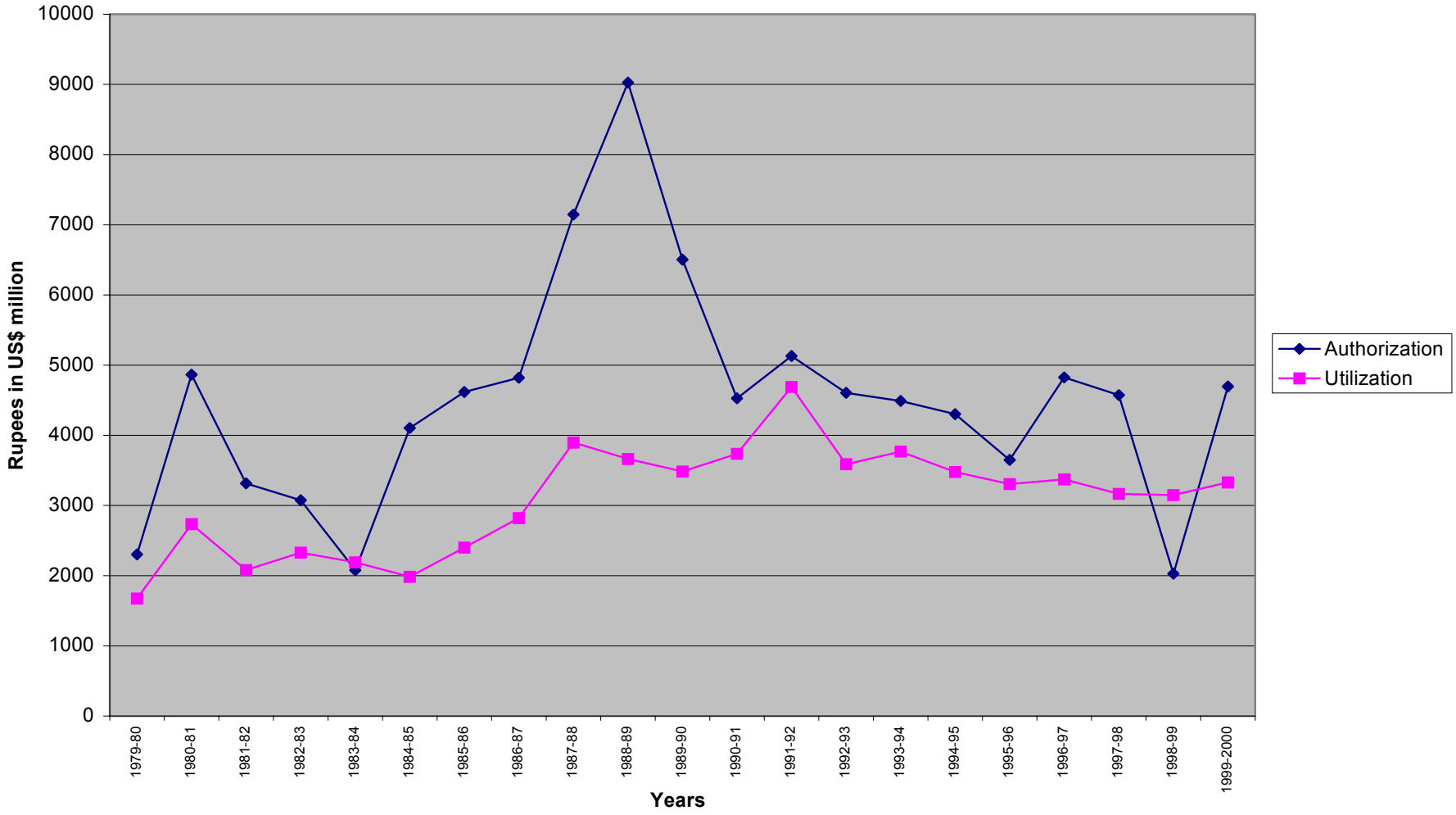
Source: Government of India, Economic Survey 2000–2001.

Table 2: Overall External Assistance (Utilisation) (US $ million)

	Loans	Grants	Total
1979-80	1298	377	1675
1980-81	2232	501	2734
1981-82	1694	385	2080
1982-83	1975	355	2330
1983-84	1898	293	2191
1984-85	1650	334	1985
1985-86	2038	362	2400
1986-87	2485	336	2821
1987-88	3528	368	3896
1988-89	3272	391	3663
1989-90	3086	399	3485
1990-91	3439	298	3737
1991-92	4318	371	4689
1992-93	3302	288	3589
1993-94	3486	283	3769
1994-95	3185	293	3478
1995-96	2987	319	3306
1996-97	3067	306	3372
1997-98	2917	248	3166
1998-99	2936	213	3149
1990-2000	3081	248	3329

Source: Government of India, Economic Survey 2000–2001.

Chart 2: Overall External Assistance (Authorization and Utilization)



Source: Government of India, Economic Survey 2000–2001.

External Assistance for Health Sector

The pre-1990 period

Analysing the trends in level of external assistance for the health sector, we find that in the initial phase, funds for the health sector came from bilateral agencies for a variety of health and population programmes. In the early 1960s, the Ford Foundation influenced the government health policy by advocating a camp approach. Around the same time, the Applied Nutrition Programme was launched in 1963 with assistance from the UNICEF, FAO, and the WHO. US assistance in the form of grants came during the 1960s and 1970s, mainly for the control and eradication of malaria. ODA (UK), DANIDA, SIDA, NORAD, and the WHO also provided funds for various disease control programmes, including for leprosy eradication. Around this time, the emphasis of such assistance shifted from health to family planning. Also gradually the role of multilateral agencies like the World Bank in providing funds for the health sector started increasing. The early 1970s saw the launching of a series of India Population Projects. The first such project was launched in 1973 with funds from the World Bank and SIDA. In all, nine such population projects have so far been set up with assistance from the World Bank.

Table 3 provides an idea about the extent of external assistance obtained from the World Bank as IDA credit and the total cost for the first seven Population Projects. Out of a total cost of US$ 744 million for these seven population projects launched during 1973–90, an IDA credit of US$ 467 million (or 62.7 per cent) came as external assistance. The first five projects termed area projects, by and large supported the accelerated establishment of service delivery for implementation of family welfare programme in the selected areas with emphasis on IEC, training, and Management Information and Evaluation Systems (MIES). They covered backward rural areas and urban slums in 7 major states of India. The sixth and seventh projects were at the national level and aimed at supporting select programme components including training, management, information systems, involvement of private sector and NGOs, social marketing, IEC, construction of sub-centres, and project administration in several states. A breakdown of project costs shows that except Population Project V, where recurrent

costs were as high as 73 per cent, in all the other projects the emphasis was on capital costs with civil works taking a lion's share of the funds. Further, while not clear by the cost categories in the table the project designs evolved over time, their focus shifting from district to state and national levels, from construction and hardware to software including IEC and training, and from concerns with details of programme implementation to its broader operational issues.

Table 3: Cost Structure of Indian Population Projects

(US $ millions)

Projects	**I**	**II**	**III**	**IV**	**V**	**VI**	**VII**
Year Effective	1973	1980	1983	1985	1988	1989	1990
US $ million							
Bank Credits and Loans	21	46	70	51	57	125	97
Total Project Cost	32	96	124	90	78	182	142
Base Cost (excl. contingencies)	-	75	97	68	60	135	137
			(per cent of base cost)				
Percent Breakdown							
Civil Works and Prof. Fees	47	40	55	58	11	41	40
Furniture, Equipment,	18	8	15	9	10	20	15
Vehicle	-	3	NA	NA	NA	1	2
IEC Material							
Consultant, Fellowships and Innovative Activities	10	2	-	-	6	12	33
Sub Total Capital Costs	75	53	70	67	27	76	89
Salaries	17	24	19	22	53	16	5
Consumables and Operations	8	23	11	11	20	8	5
Sub Total Recurrent Costs	25	47	30	33	73	24	11
Consumables and Operations	8	23	11	11	20	8	5
Sub Total Recurrent Costs	25	47	30	33	73	24	11

Note: NA: not available.
Source: The World Bank and India's Population Problem, India-Population/ May 17, 1991 (mimeo).

The other two Population projects, namely IPP VIII & IPP IX, are active and are to close in 2001. The total costs of these two projects is US$ 200.4 million out of which

available IDA credit is US$ 167.6 (83.6 per cent). The first five Population Projects were aimed at assisting the government to carry out its family planning-cum-maternity and children (MCH) programmes. In 1976, the programme came to be known as Family Welfare (FW) programme. It may be pointed out that until now the World Bank had little influence on the direction of these projects for some of the following reasons as indicated in Bank's evaluations:

- India's population programme was firmly established prior to the time that the Bank became involved.
- The IDA assistance was a small portion of the total expenditure incurred by the Union Government on family welfare (under 4 per cent).
- Despite significant combined donor inputs (around 12–14 per cent), there was little co-ordination or pressure from the Bank to influence the approach.
- The Bank assigned few people to work on this sector with limited field presence. The Bank had not yet undertaken any sector work and did little to develop alternative approaches to service delivery or to encourage the involvement of other sectors (e.g. education and health) that could help in generating demand for smaller families.

The available evaluations suggest that the overall goal of these projects to accelerate service delivery network for the family welfare programmes in specific districts was not achieved except in a couple of districts. Also the Bank accepted the low key, passive role.

Besides obtaining funds for the health sector from the World Bank, the Union Government was also able to get the support of UNFPA, DANIDA, and ODA (UK) for area projects in five other states, namely, Rajasthan, Bihar (UNFPA), Madhya Pradesh (MP) and, Tamil Nadu (TN) (DANIDA), and Orissa (ODA UK). In MP and TN, support was extended to leprosy control programme. Around this period (1980-85), WHO, SIDA, NORAD, and USAID, provided financial and technical support in both health and

family welfare programmes. WHO provided US$ 30 million as assistance towards provision general medical supplies, equipment, training, and research. During 1985–90, UNICEF provided support to the tune of US$ 29 million for EPI, STDs, ORT and PHC, besides contributing towards training, vehicles, vaccines, TB, leprosy, and Malaria Control Programmes. NORAD supported Post Partum Programme (NOK 378.5 million during 1969–88) and USAID support of US$ 33 million, among other areas, was for the development of Contraceptive Marketing Organisation (1980–86).

The decade 1980–90 also saw launching of the Tamil Nadu Integrated Nutrition Programme (TINP) with an IDA credit of US$ 32 million. The focus was on health and nutrition.

Table 4: Bilateral and Multilateral Assistance to Health and Family Welfare 1960-90

Donor	Purpose	States Covered	Amount of Funding (in US$ million)
UNICEF, FAO WHO (1961-66)	Supported the launching of Applied Nutrition Programme	NA	NA
NORAD (1969- 88)	Supporting post partum programme in urban and semi urban areas	NA	NK 378.5
UNFPA (1974-90)	Providing support in cash and kind to Family Welfare Schemes, manufacturing of contraceptives, development of population education programmes, strengthening program management, training lower level health workers and introducing innovative approaches in Family Planning and MCH	NA	184
WHO (1984-87)	Providing general medical supplies, equipment, IEC material, training of Indian experts and supporting research projects.	NA	30
UNICEF (1980-86)	Support to MCH and imminisation programme	NA	9.44
UNFPA (1980-86)	Support to Family Welfare Programme	Area project : Rajasthan (4 districts) Bihar (11 districts)	50
DANIDA (1981-86)	Providing support to leprosy control programme	Area project MP (8 districts) TN (2 districts)	**DK 230**

Donor	Purpose	States Covered	Amount of Funding (in US $ Million)
ODA (UK) (1981-86)	Support to Family Welfare Programmes	Area Project: Orissa (3 districts)	15.2
SIDA (1984-89)	Providing equipment and support for TB, Leprosy and Malaria Control		SK 125
	Programme		
USAID (1980-86)	Support to Family Welfare Programme	Area Project: Punjab(3 districts) Haryana(3 districts) Himachal Pradesh (3 districts) Maharashtra (3 districts)	33
USAID (1981)	Strengthening private and voluntary sectors to expand and improve basic and special preventive health, family planning and nutrition programme		20
WHO (1988-89)	Research under Human Reproduction Programme		2.08
UNICEF (1985-90)	Providing support to Health programmes particularly the Expanded Programme of Immunisation (EPI), Sexually Transmitted Diseases (STD), Oral Rehydration Therapy (ORT), and Primary Health Care, support to health worker training and provision of vehicles, syringes needles and vaccines		US 29
UNFPA (1989-94)	Support to Family Welfare Programme	Area Project Phase II Rajasthan (11 districts)	US 14.05

Donor	Purpose	States Covered	Amount of Funding (in US $ Million)
DANIDA (1985-89)	Provision of mobile units, developing infrastructure in district hospital and primary health centres/manpower devlopment in Ophthalmic institutes and building a strong MIES		
DANIDA (1989-92)	Provision of equipment, vehicles, health education materials, upgradation of ophthalmic services, maintenance and repair	Area Project: Phase II MP (8 districts) TN (2 districts)	DK 126.56
ODA (UK) (1989-94)	Support to Family Welfare Programme	Area Project: Phase II Orissa (5 districts)	PD Stg. 20
NORAD (1988-91)	Training and management activities and post partum programme		NK 90
WHO (1990-91)	Provision of Family Welfare and MCH services in urban areas		US $ 0.3

Note: NA: not available.
Source: *SAR*, IPP VIII, May, 1992, pp. 61–62.

As far as SIDA's involvement in TB programme since the 1970s is concerned the assistance was in the form of equipment and materials (e.g. X-ray units, film rolls, drugs, jeeps). Later, SIDA funds were routed through WHO to procure various materials required for the programme.

The second half of the 1980s saw the launching of the Blindness Control Programme with the support DANIDA. ODA (UK) also extended support to the programme in the form of technical assistance for research and consultancy and the visits of experts from abroad. During the Blindness Control Programme, DANIDA provided funds to the extent of DK 126.56 million. Table 4 provides the necessary details of external assistance received for various health projects and family welfare projects from bilateral and multilateral agencies other than the World Bank.

Table 5: External Funding for India for Health during 1970s

S. no	Agency	Amount Funded ($ Million)	% to total
1	US Government	493	57.4
2	UNICEF	134	15.6
3	WHO	53	6.3
4	UNFPA	42	4.9
5	World Bank	91	10.7
6	Ford Foundation	10	1.3
7	Rockfeller Foundation	5	0.6
8	Swedish IDA	11	1.4
9	Norwegian IDA	9	1.0
10	UK (ODA)	6	0.8
	Total	859	100

Note: The percentage of external funding has been calculated from the original table.
Source: Jaffery, R., 'New Patterns in Health Sector Aid', IJHS, Vol. 16, No. 1, p. 126.

Table 5 gives an idea of the total funds received from various donors during the 1970s. The figures in the table clearly show the dominant position of the US government, which alone contributed 57.4 per cent of the total external assistance to the health sector. As far as other bilateral aid during this period is concerned, their contribution was very

small. If we compare the relative contribution of various donors to the health sector during 1985–90 (Table 6), we, however, observe that the World Bank became the single largest provider of external assistance to the health sector (from about 33 per cent in 1985–86 to 66 per cent in 1989–90). Other major donors during this period were UNICEF, USAID, and UK

Table 6 : International Assistance received during 1985–90 for Health and Family Welfare

(in lakh Rupees)

S.no	Name of the Foreign Agency	1985–86	1986–87	1987–88	1988–89	1989–90
1	World Bank	1807.2 -32.5	1757.07 -25.74	2616.06 -31.82	1387.41 -20.49	14171.96 -65.6
2	NORAD	99.98 -1.8	106.76 -1.56	804.43 -9.79	698.58 -10.32	818.4 -3.78
3	UNICEF	720 -12.93	1843.51 -27	1595.44 -19.41	2229.5 -32.93	2167.69 -10.03
4	DANIDA	510 -9.16	820.62 -12.02	636.42 -7.74	-	450 -2.08
5	WHO	136.98 -2.46	-	149.94 -1.82	-	266.81 -1.23
6	UNFPA	1739.2 -31.22	1052.75 -15.42	847.17 -10.3	1528.51 -22.58	1530.6 -7.08
7	UK	363.3 -6.52	122.81 -1.8	241.19 -2.93	-	-
8	USAID	102.93 -1.85	1122.81 -16.45	1329.33 -16.17	926.45 -13.68	2195.04 -10.16
9	Others	89.55 -1.61	-	-	-	-
	Total	5569.14	6826.33	8219.98	9770.45	21,600.45

Note: Figures in brackets represent percentages.

Source: World Bank, India's Health Sector Financing, Coping with Adjustment Opportunities and Reform, 1992.

The Post 1990 period

The post 1990 period saw the launching of several new projects by both multilateral and bilateral donors. This period saw the lead role of the World Bank in providing credit for numerous health, nutrition, and reproductive health projects. We first provide a brief description of the World Bank supported projects. Table 7 provides a list of the projects supported by the World Bank in the health sector. The post 1990 World Bank supported Population Projects were guided by a sector strategy mutually agreed by the Government of India and the Bank. The main features of the strategy were:

- greater emphasis on outreach
- greater emphasis on temporary methods versus sterilisation
- increased attention to MCH
- less project resources for expansion of the system and more for enhancing quality of service delivery, training, and IEC
- priority to improving these services in urban slums and backward, high fertility states not covered by previous projects.

Thus apart from the nine IPPs, a new project called the Child Survival and Safe Motherhood (CSSM) Project based on the above principles was launched in 1992 with IDA/World Bank credit of US$ 214.5 million. The project provided direct budgetary support for the incremental costs to the MCH programmes. In particular, CSSM supported two new programmes: Universal Immunisation Programme (UIP) Plus and Safe Motherhood, besides creating infrastructure in 90 backward districts for first referral units. This was followed by the Reproductive and Child Health Project launched in 1997 with IDA/World Bank credit of US$ 248.3 million.

Table 7: HNP leading in India, FY76 – FY96 and projected to FY99

Approval-Completion	Ln./Cr. Number	Project Name	Project Status	Project Cost ($M)	Loan ($M)	OED Report	Rating	Sustainability
1973-1980	Cr.312	Population (Karnataka, Uttar Pradesh)	Completed	Na	21.2	Audit	Sat.	Na
1980-1989	Cr.1003	Tamil Nadu Integrated Nutrition	Completed	Na	32.0	Impact	Sat.	Likely
1980-1988	Cr,981	Second Population (IPP2) (Uttar Pradesh, Andhra Pradesh)	Completed	Na	46.0	Audit	Unsat.	Likely
1983-1992	Cr.1426	IPP3 (Karnataka, Kerala)	Completed	Na	70.0	PCR	Sat.	Uncertain
1985-1994	Cr.1623	IPP4 (West Bengal)	Completed	89.9	51.0	PCR	Sat.	Uncertain
1988-1996	Cr.1931	IPP5 (Bombay, Madras)	Completed	77.2	57.0	ICR	Sat.	Likely
1992-1996	Cr.2300	Child Survival and Safe Motherhood	Completed	214.5	214.5	ICR	Sat.	Likely
4989-1997	Ln.3108/ Cr.2057	IPP6 – Family Welfare Training and Systems Development) UttarPradesh, Andhra Pradesh, Madhya Pradesh	Completed	113.3	11.3	ICR	Sat.	Likely
1990-1998	Cr.2158	Second Tamil Nadu Integrated Nutrition	Completed	139.1	95.8	ICR	Marginally Sat.	Likely
1990-1997	Ln.3253/ Cr.2173	Integrated Child Development Services (Orissa, Andhra Pradesh)	Completed	157.5	106.0	ICR	Unsat.	Likely
1990-1998	Ln.3199/ Cr.2133	IPP7 (Training)	Completed	156.7	96.7	ICR	Sat.	Likely
1992-1994	Cr.2448	Social Safety Net Sector Adjustment Program	Completed	500.0	-	ICR	Sat.	Likely
						Most Recent Supervision Rating		
						IP	**DO**	
1992-1999	Cr.2350	National AIDS Control	Active	99.6	84.0	High Sat.	Sat.	
1992-2001	Cr. 2394	IPP8 Family Welfare (Urban Slums)	Active	96.6	79.0	Sat.	Sat.	
1993-2000	Cr. 2470	Second Integrated Child Development Services (Bihar, Madhya Pradesh)	Active	248.8	194.0	Unsat.	Unsat.	
1993-2000	Cr,2528	National Leprosy Elimination	Active	138.3	75.93	High Sat.	Sat.	
1994-2001	Cr.2611	Cataract Blindness Control	Active	135.7	117.8	Sat.	Sat.	
1994-2001	Cr.2630	IPP9 – Family Welfare (Assam, Rajasthan, Karnataka)	Active	103.8	88.6	Sat.	Sat.	
1995-2002	Cr. 2663	Andhra Pradesh First Referral Health System	Active	159.0	133.0	Sat.	Sat.	
1996-2002	Cr.2833	Second State Health Systems Development	Active	416.7	350.0	Sat.	Sat.	
1997-2002	Cr.2936	Tuberculosis Control	Active	176.4	142.4	Unsat.	Sat.	
1997-2003	Cr.2964	Malaria Control	Active	165.0	164.8	Unsat.	Sat.	
1997-2003	Cr.2942	Rural Women's Development and Empowerment	Active	53.8	19.5	Unsat.	Sat.	
1997-2003	Cr.No18	Reproductive and Child Health Care	Active	309.0	248.3	Sat.	Sat.	
1998-2004	Cr.No 410	Orissa Health Systems Development	Active	90.7	76.4	Sat.	Sat.	
1998-2003	-	Women and Child Development	Active 422.3	300	-	-		
1999-2005	-	Maharashtra Health Systems Development	Entry	158.1	134.0	-	-	
1999		Second AIDS Prevention	Planned	200.0	125.0	-	-	
2000		UP Health Systems	Planned	244.0	200.0	-	-	
2001		Second Reproductive and Child Health Care	Planned	300.0	250.0	-	-	
2001		Rajasthan Health System	152.0	150.0	-	-		

PCR = Project Completion Report, ICR = Implementation Completion Progress, DO = Development Objective
Source: World Bank data.

The design of RCH project is based on sector work and consultations with key stakeholders. The RCH has dropped the target approach and encourages the development of different implementation models in different situations. It has also introduced some elements of performance-based budgeting and builds monitoring and client feedback into the heart of the project. One of the major gains of the project was the entry of the European Union as a partner in the RCH project. It has provided assistance of over US$ 200 million.

In addition to the population projects, the World Bank has provided credit of US$ 95.8 million to TINP-II project (1990–98). The TINP project was designed largely by the Bank staff/consultants and focussed on changing the way mothers feed themselves and their pre-school children. One of the strengths of this project was the fact that it was well monitored and evaluated. The World Bank is also supporting the ICDS programme. In the two IDA supported ICDS projects, credit to the extent of US$ 300 million has already been provided.

Besides population and nutrition projects since 1992, the World Bank has provided considerable support to the health projects. Under this type of assistance, two types of projects are being supported: Specific Disease Control Programmes, and State Health System Projects. The disease control programmes are aimed at assisting the government with its vertical programmes. The experience of the Bank gained elsewhere and the involvement of private sector and the NGOs have helped a great deal in reducing the prevalence of leprosy and cataract blindness. There is also an improvement in the detection and treatment of TB and improvements in the protective behaviour of high-risk groups. It is reported that the Malaria Control Project has not brought about any good results. Apart from the AIDS II project, which is likely to get an IDA credit of US$ 125 million, the five disease control projects have got an IDA credit worth US$ 584.93 million.

The State Health System Projects supported by the Bank are aimed to influence more fundamental determinants of how the public health system works. Since these projects are at the state level, the Bank has clearly greater leverage than it is possible at the national level, and accordingly is in a position to provide assistance appropriate to vastly different states. The first State Health System Project launched in Andhra Pradesh focused on improving secondary level hospitals. This is done as a first step towards establishing an adequate referral system between primary and secondary institutions. Subsequently State Health System Projects covered West Bengal, Karnataka, and Punjab for which an IDA credit of US$ 350 million was made available (1996–2002). Subsequently Maharashtra, Orissa, and UP have also been provided an IDA credit of US$ 410.4 million. The State Health System for Rajasthan is also under active consideration by the Bank, and it is expected to obtain an IDA credit worth US$ 150 million. All these SHS projects are essentially extending the principles of the first project initiated in AP. Although in some cases more work at the primary level has been added in the subsequent projects, but the basic goal of establishing a working referral system has remained intact.

Recently an IDA credit of US$ 142.6 million has been proposed for an Immunisation Strengthening Project with the objective to

- eradicate poliomyelitis, and
- reduce vaccine preventable diseases through immunisation programme

As mentioned earlier, during the post 1990 phase, external assistance has continued to flow from other donors as well. In this class of donors the Department for International Development, UK has been providing a regular flow of external assistance for the health sector in India. Currently the DFID India contributes about £20 million annually with a view to bringing about substantial improvements in health of the poor in India. The DFID-India support is provided to the Government of India and to Andhra Pradesh, Orissa, West Bengal, and Madhya Pradesh, which they have adopted as focus states. The DFID-India's emphasis on strengthening health systems is a key to delivery of priority services to poor people. Another significant DFID operation in India is to work in

partnership with other multilateral agencies such as the World Bank, and the European Union, and the UN System such as WHO and UNAIDS to strengthen their mandate. Specifically DFID-India is currently working to improve access to reproductive health services, communicable disease control such as TB, child health, and HIV epidemic. Table 8 provides an idea of the magnitude of assistance that DFID-India is providing for health programmes. In addition, particular mention may be made of DFID India's commitment of over £25 million to rehabilitation of health services in Orissa following the cyclone of 1999. Besides, since 1995, DFID-India has committed £87 million towards the polio eradication programme.

As mentioned earlier, apart from the World Bank and DFID-India, other bilateral and multilateral agencies have also continued to provide funds for the health sector during the post 1990 period. Table 9 contains a list of the projects for which India has received assistance from bilateral and multilateral agencies and governments other than the World Bank. In this context, mention may be made of funds provided by DFID-India, UNFPA, UNICEF, Canada, SIDA, KFW, Japan, and the USAID.

According to an analysis carried out by DAC Secretariat (OECD), the flow of total ODA assistance for health to India from OECD member countries including that coming through multilateral development banks during 1990–96 has been as follows:

Table A: Flow of ODA Funds to India for Health

	1990–92	**1993–95**	**1996–98**
Total average annual flow of ODA funds to India for health (US$ million)	305	268	623

Table 8: Recent External Assistance for Health to India from DFID India

Location	Value	Start Date	End Date	Partner
National	£0.8 Million	Sept. 1997	November 2000	GOI and partner states
National	£6.14 Million	March 1997	Mar-00	GOI and NGO
National	£1.1 Million	Sept. 1999	30th September 2000	Ministry of Health and Family Welfare, Ministry of Broadcasting
Orissa	£2.5 Million	June 1997	Jun-00	Government Of Orissa
Orissa	£5.00 Million	1st April 1997	Mar-03	Implementing NGO Orissa
Other States	£31.74 Million	Mar-96	Apr-04	States AIDS Cell – Kerala, Gujarat, AP and Orissa
National	£47.91 Million	Dec-95	Mar-00	Government of India
Andhra Pradesh	£20.2 Million	Apr-98	Mar-04	Government of Andhra Pradesh
Other States	£4.6 Million	Apr-95	Jun-00	GOI, NMEP, GOG, LSHTM and some institutions.
National	£0.72 Million	Dec-94	Mar-00	WHO
West Bengal	£3.97 Million	Apr-95	Mar-00	GoWB & NGOs
National	£0.8 Million	1994	Dec-99	GOI and ASCI

Source: DFIDI website and micro documents.

Table 9: Recently Funded Projects Other than the World Bank

Donor	Sector		Funds		Time Frame	
		Project Title	Unit	Amount		Geographic Coverage
A. Nation-wide (NW) externally funded projects/programmes/activities						
UNFPA	FW	RH Sub-programme: Integrated	$Million	50	1997-2001	33 districts and 4 urban slums spread across 8 states
		Population and Development (IPD)				states (NW1.2/): of which 5 districts would have intensive
		Projects. (NW1.1/)				RH interventions (NW1.3/)
UNFPA	FW	RH Sub-programme: Population and	$Million	14+	1997-2001	All-India plus state/institution specific projects.
		Development Strategies (NW1.6/)				
UNFPA	FW, Health, Women in	Sub-programme on Advocacy	$Million	8+		All India
	Development, and	(NW1.8/)				
	Advocacy					
UNFPA	-	-	-	-	-	-
UNICEF	FW & Health (NW2.1/)	GOI - UNICEF RCH Programme	$Million	125	1998-2002	Nationwide (See contents of Remark Column)
		(NW 2.2/)				
UNICEF	-	-	-	-	-	-
UNICEF	FW & Health	Integrating Child Health & Survival	$Million	NA	1998-2002	Varies according to activities.
		(NW 2.3/)		(NW 2.4/)		
UNICEF	FW & Health	Safe Motherhood & Women's	$Million	NA	1998-2002	Varies according to activities.

		Health				
		(NW 2.7/)		(NW 2.4/)		
UNICEF	FW & Health	Community Action for Health (NW2.11/)	$Million	NA	1998-2002	Varies according to activities.
				(NW 2.4/)		
UNICEF	FW & Health	Enhancing supply Management for	$Million	NA	1998-2002	Varies according to activities.
		Primary Health Care (NW2.12/)		(NW 2.4/)		
UNICEF	FW & Health	Training (NW2.14/)	$Million	NA	1998-2002	Varies according to activities.
				(NW 2.4/)		
UNICEF	FW & Health	Other projects	$Million	NA	1998-2002	Varies according to activities.
				(NW 2.4/)		
DANIDA	FW	Pulse Polio	DKK Million	56	Beyond 2001	(NW4.1/)
(NW4.1/)						
DANIDA	Health	Blindness	DKK Million	76	Beyond 2001	(NW4.1/)
(NW4.1/)						
DANIDA	Health	Leprosy	DKK Million	55	Beyond 2001	(NW4.1/)
(NW4.1/)						
DANIDA	Health	Tuberclousis	DKK Million	32	Beyond 2001	(NW4.1/)

(NW4.1/)						
DFID	Health	ISH-PPP (NW5.1/)	£ Million	32	1996-2004	Focus on Kerala, Gujarat, Orissa,
						Andhra Pradesh (NW5.2/)
DFID		ISH	-	-	-	-
		Project				
DFID	ISH	Truckers, Project	-	-	-	-
	Project	PPP				
	(NW5.2/)	(NW5.3/)			1997-1999	
DFID	Health	RNTP (NW5.4/)	£ Million	20	1998-2004	Government of Andhra Pradesh
DFID	FW	Pulse Polio	£ Million	48	1995-2000	
		Immunisation				
DFID	Health	TB-OR				
		(NW5.6/)			1995-1997	
DFID	FW &	Knowhow			2 years	DFID focus states.
DFID	Health	Facility (NW5.7/)				
DFID	Health	Blood Safety				All India
		Programme (NW5.9/)				
GTZ	See remarks					
KFW	FW	Pulse Polio	DM Million	50	On going	All India
KFW	FW	Special Marketing	DM Million	15	On going	All India
SIDA	FW	CSSM-II	Million	175	1995-1998	All India

			SEK			
		(NW8.1/)				
USAID	FW & Health	NFHS-II (NW9.1/)				All India
USAID	FW & Health	Joint Indo-US Contraceptive and				All India
		Reproductive Health Research				
		Initiative				
USAID	FW & Health	Polio Eradication in India				All India
USAID	Nutrition	PL480 Title II			1995-2003	All India
		Programme				
USAID	FW & Health	PACT/CRH Project (S24.3)	$ Million	20	1995-2000	Nation-wide with focus on USAID Project states districts

Note: NA: Not available.

Source: An Overview for External Funding for the Activities in Family Welfare and Related Sectors', GOI and European Commission, May 1999 (mimeo).

It may be mentioned that during this period, India was the top recipient country in the world in terms of the absolute value of aid to health. However in terms of the percentage of total receipts, its rank for example in 1996-98 was only ninth amongst ten top recipient countries. The share of aid to health in India's total receipts was around 19 per cent during 1996-98, compared to say 41 per cent for Nigeria and 32 per cent for Congo Democratic Republic in the same period, being the top two countries. Within Asia, however, India's share of aid to health in total receipts was the highest. An analysis of the sub-sectoral breakdown of ODA for health for all recipient countries shows that

- for DAC countries bilateral aid almost one-third of contributions were in support of basic health, slightly over one-third in support of reproductive health care/population activities, with remainder covering general health programmes (non-basic) health services;
- for total aid including lending by development banks, 30 per cent were for basic health, 34 per cent for reproductive health and population activities, and the remaining for general health programmes; and
- multilateral aid contributed about 40 per cent for general health sector programmes, 16 per cent for reproductive health, and 10 per cent for disease control.

Exploring Development Co-operation: The Case of the Database of UNDP 1994

A recent UNDP report of 1994 on external assistance provides us some very interesting insights about the size and diversity of external assistance for health to India. A word about the database used in this analysis: The data on external assistance presented by UNDP was compiled on the basis of questionnaires sent to bilateral and multilateral donor agencies as well as to external non-governmental organisations (NGOs). In its inaugural attempt the information was received from 15 bilateral donors, 17 multilateral donors, and 5 NGOs.

Table 10: External Assistance Disbursement by Donors in the Health Sector, 1994

Donors	Health Sector			All Sectors
	Amt ('000 USD)	% distribution	As % of all sectors	Amt (100 USD)
I. Multilateral	**148,852**	**44.22**	**12.23**	**1,217,599**
1. UN Systems	**148,852**	**44.22**	**12.76**	**1,166,641**
ESCAP	0	0.00	0.00	2
FAO	65	0.02	33.85	192
IDA	83,657	24.85	8.42	993,381
IFAD	0	0.00	0.00	17,127
ILO	0	0.00	0.00	80
UNDCP		0.00	0.00	482
UNDP	200	0.06	0.76	26,301
UNESCO	0	0.00	0.00	60
UNFPA	10,864	3.23	89.90	12,085
UNHCR	0	0.00	0.00	3226
UNICEF	39,814	11.83	52.92	75,238
UNIDO	0	0.00	0.00	598
WFP	12,513	3.72	34.82	35,938
WHO	1804	0.54	94.01	1919
WMO	0	0.00	0.00	12
2. Non-UN Systems	**0**	**0.00**	**0.00**	**50,958**
ADB	0	0.00	0.00	2461
EU	0	0.00	0.00	48,497
II. Bilateral	**60,959**	**18.11**	**6.50**	**937,963**
Australia	0	0.00	0.00	2909
Canada	0	0.00	0.00	38,804
Denmark	6231	1.85	32.84	18,972
France	123	0.04	7.11	1731
Germany	25,947	7.71	21.20	122,413
Japan	585	0.17	0.10	586,760
Netherlands	55	0.02	0.32	17,408
Norway	234	0.07	4.15	5633
New Zealand	3	0.00	16.67	18
Sweden	16,396	4.87	43.00	38,134
Switzerland	0	0.00	0.00	17,695
UK	7361	2.19	12.26	60,036
USA	4024	1.20	14.66	27,450
III. NGO	**126,808**	**37.67**	**84.48**	**150,112**
Aga Khan Foundation	0	0.00	0.00	23
Care	126,788	37.67	99.91	126,908
Christian Children's Fund	20	0.01	0.11	17,665
Save the Children Fund - UK	0	0.00	0.00	5516
Grand Total	**336,619**	**100.00**	**9.77**	**3,444,707**

Source: UNDP, *India: Development Cooperation Report, 1994.*

In all, 864 projects were under progress by the end of 1994 of which 142 projects were in the health sector. In terms of total assistance of US$ 3444.7 million disbursed by donor agencies during 1994, the health sector received only US$ 336.6 million (9.8 per cent). It is clear from Table 10 that there is a wide variation in assistance to the health sector among donor agencies. Among multilateral agencies ADB, ESCAP, EU, IFAD, ILO, UNESCO, UNHCR, UNIDO, and WMO, and among bilateral agencies Australia, Canada and Switzerland and amongst NGOs, the Aga Khan Foundation and SCF did not disburse any assistance during 1994 for the health sector. On the contrary, IDA, UNICEF, Germany, and Care were the major contributory agencies in the health sector. Interestingly, irrespective of the size of assistance FAO, UNFPA, UNICEF, WFP, WHO, Denmark, Germany, Sweden, and Care had devoted a significant portion of their total assistance to health sector. In fact, Care, WHO, and UNFPA allocated more than 90 per cent of total assistance to health sector.

Table 11: External Assistance Disbursements in Health by Sub-sector (1991–95)

Health Sub-sector	1991	1992	1993	1994	1995 (Planned)
Sectoral Policy & Planning	11.87	16.33	13.44	30.91	58.87
Primary Health Care	43.44	40.95	32.63	33.32	15.13
Immunisation & Disease Control	33.76	33.91	50.51	31.20	25.26
Family Planning	9.00	7.68	3.26	2.10	0.58
Hospitals & Clinics	1.92	1.13	0.17	2.47	0.16
All	100.00	100.00	100.00	100.00	100.00
Total Health ('000 USD)	152,296	204,766	152,862	338,011	572,577
Total All Sectors ('000 USD)	3,140,406	4,457,349	2,453,963	2,305,674	3,916,943
Share of Health Sector (%)	4.85	4.59	6.23	14.66	14.62

Source: UNDP, *India: Development Co-operation Report 1994,* New Delhi, November 1995.

The UNDP database classified various health projects into five sub-sectors (namely sectoral policy & planning; primary health care; immunisation & disease control; family planning; and hospitals & clinics). Table 11 presents the share of disbursements by sub-sector during 1991–95. It is quite indicative from the data that over time the share of external assistance towards sectoral policy & planning has risen while the share has declined both for primary health care as well as immunisation & disease control sub-sectors. By 1995, the share of family planning almost became negligible.

However, the share of health sector in total disbursement has increased from around 5–6 per cent during 1991 and 1993 to around 15 per cent during 1994 and 1995.

Table 12: Distribution of Projects and Commitment by Agency with Primary Focus of Assistance, 1994

Agency		Primary Focus of Assistance								Commitment ('000 USD)	
		Advocacy	Capacity Building	IEC	Infrastructure	Research	Service Delivery	Training	Total	Amount	%
Multilateral	FAO		1	1					2	386	0.02
	IDA	1					5	2	8	920,657	44.62
	UNDP			1		1		1	3	1524	0.07
	UNFPA	3	4	1			6	1	15	57,162	2.77
	UNICEF		1	1	1		1		4	190,850	9.25
	WFP						1		1	65,800	3.19
	WHO	6	16	3		13	2	1	41	17,234	0.84
	Sub total	10	22	7	1	14	15	5	74	1,253,613	60.75
Bilateral	Belgium		1						1	307	0.01
	Canada					1	1		2	2930	0.14
	Denmark		1			1	5		7	55,377	2.68
	France	2				1			3	856	0.04
	Germany						1		1	28,830	1.40
	Italy		1						1	9866	0.48
	Japan		1						1	55,146	2.67
	Netherlands							1	1	412	0.02
	Norway					1	4		5	143,881	6.97
	New Zealand		2						2	3	0.00
	Sweden						3		3	68,092	3.30
	UK	1	4	2	1	4	2	1	15	75,509	3.66
	USAID		2			1	2		5	364,488	17.66
	Sub total	3	12	2	1	9	18	2	47	805,697	39.05
NGO	CARE			3			9		12	3343	0.16
	CRS	1						1	2	10	0.00
	FF		1	4		1		1	7	797	0.04
	Sub total	1	1	7		1	9	2	21	4150	0.20
Total		14	35	16	2	24	42	9	142	2,063,460	100.00
Row %		9.9	24.6	11.3	1.4	16.9	29.6	6.3	100		

Source: *India: Development Cooperation Report, 1994.*

After going through the detailed objectives of each health projects, we have identified primary focus of the external assistance and categorised them into seven groups. Of the 142 projects, service delivery as the primary focus was observed for 30 per cent of projects and for another 25 per cent projects it was capacity building

(Table12). Research, IEC, and advocacy accounted for 17 per cent, 11 per cent, and 10 per cent, respectively. Only in 9 projects (6 per cent) the primary focus was training and in 2 projects (1 per cent) it was infrastructure development. The primary focus differed by type of the donor agency. For instance, the relative share of multilateral agencies was higher in research and capacity building projects, whereas the share of bilateral agencies was higher in service delivery and that of NGOs in IEC projects.

In terms of total commitment of US$ 2063 billion, the share of multilateral agencies was 61 per cent of which IDA was the highest (45 per cent). In terms of distribution of total commitment by type of project, the share of service delivery projects was the highest (70 per cent). Training, advocacy, capacity building, and IEC projects together accounted for only one-fourth of the total commitment (Table13).

Table 13: Distribution of Total Commitment and Disbursement by Primary Focus of External Assistance

Primary Focus	No. of Projects		Commitment ('000 USD)		Disbursement, 1994 ('000 USD)	
	Frequency	Per cent	Amount	Per cent	Amount	Per cent
Advocacy	14	9.86	89,476	4.34	5469	2.54
Capacity Building	35	24.65	120,367	5.83	7265	3.37
IEC	16	11.27	125,150	6.07	27,254	12.65
Infrastructure	2	1.41	85,149	4.13	11,929	5.54
Research	24	16.90	27,348	1.33	3159	1.47
Service Delivery	42	29.58	1,441,535	69.86	134,826	62.57
Training	9	6.34	174,435	8.45	25,590	11.88
Total	142	100.00	2,063,460	100.00	215,492	100.00

Source: UNDP, *India: Development Cooperation Report 1994.*

The health projects were of varying duration from 1 to 13 years of which 40 per cent were of three years duration. Out of the total of 142 projects, for 32 projects commitment began before 1990, for 18 in 1990, for 14 in 1991, for 48 in 1992, for 9 in 1993, and for the remaining 21 projects in 1994. Only 12 projects were given directly to NGOs and another 14 projects to various government institutes (of which 3 were given to the National Institute of Health and Family Welfare, New Delhi) and the large chunk of 111 projects were sanctioned to various state and central health ministries and the remaining 5 projects to other central government ministries. If one looks at the

geographical distribution of the projects, then 90 out of 142 projects were at the national level, the remaining 52 were for specific states. (The state level distribution was: Delhi 9; Tamil Nadu 7; Gujarat 6; AP 5; 4 each to Maharashtra, Orissa, and West Bengal; Karnataka 3; 2 each to Bihar, Madhya Pradesh, Rajasthan, and UP; and 1 each to Assam and Himachal.) However, four major states of Haryana, Jammu & Kashmir, Kerala and Punjab were left out.

Table 14: Distribution of Total Commitment and Disbursement by Broad Area of External Assistance

Broad Area	No. of Projects		Commitment ('000 USD)		Disbursement, 1994 ('000 USD)	
	Frequency	Per cent	Amount	Per cent	Amount	Per cent
Child Survival & Safe Motherhood	9	6.34	282,743	13.70	51,106	23.72
Disease Control	49	34.51	192,711	9.34	11,734	5.45
Health Education	5	3.52	1107	0.05	120	0.06
Family Planning/Contraceptives	7	4.93	340,080	16.48	2442	1.13
Family Welfare	20	14.08	387,070	18.76	39,725	18.43
Health Research	9	6.34	71,046	3.44	1475	0.68
Health Information System	4	2.82	1327	0.06	90	0.04
ICDS	12	8.45	535,445	25.95	41,645	19.33
Immunisation	2	1.41	123,180	5.97	26,868	12.47
Health Infrastructure	1	0.70	35,149	1.70	2335	1.08
Health Management	6	4.23	4723	0.23	306	0.14
Medicine & Drugs	5	3.52	33,336	1.62	26,887	12.48
Food/Nutrition	4	2.82	16,050	0.78	3017	1.40
Primary Health Care	4	2.82	26,918	1.30	3266	1.52
Training	5	3.52	12,575	0.61	4476	2.08
Total	142	100.00	2,063,460	100.00	215,492	100.00

Note: The break-up of number of projects for disease control is AIDS (8), ARI (7), leprosy (5), blindness (4), cancer (3), malaria (3), disability (2), Vitamin A deficiency (2), TB (2), parasitic diseases (2) and one each for dental, diarrhoea, guinea worm, heart, hepatitis, injury, kala azar, STDs, reproductive diseases, and non-communicable diseases.

Source: *India: Development Cooperation Report 1994.*

Table 14 presents the distribution of 142 projects by broad area of external assistance within the health sector. In all, 15 areas were broadly identified. A larger number of projects was concentrated in the area of disease control programmes (35 per cent) followed by family welfare (14 per cent) and ICDS (8 per cent). Of the total 49 disease control programme projects, eight projects pertained to AIDS, seven to acute respiratory infections, and five to leprosy. Nine projects provided assistance to CSSM and the same number to health research programmes. It is interesting to note that six

projects were in the area of health management and another four projects for the development of health information system. In the light of liberalisation and IT revolution, the assistance in health management and information system is highly required for efficient management of scarce resources in the health sector. However, in terms of total commitment the share of these 10 projects is very small (0.3 per cent only). Overall there is less skewed distribution of commitments/disbursements than the number of projects by area of assistance. About three-fourths of the total commitments were in the four broad types of projects, namely ICDS (26 per cent), family welfare (19 per cent), family planning/contraceptives (16 per cent) and CSSM (14 per cent). However, the importance differs notably in terms of disbursements made during 1994. Here CSSM accounted for 24 per cent of total disbursements followed by ICDS (19 per cent), family welfare (18 per cent), medicine & drugs (12 per cent), and Immunisation (12 per cent). The share of family planning or contraceptives in the total disbursements turned out to be very small due to the fact that these projects were operational since long and were almost at the state of completion during 1994, as a result of a large chunk of disbursements which had already been made prior to 1994.

It may be mentioned that the actual figures of external assistance may somewhat differ from the ones presented in the preceding discussions: This is clear from a comparison of summary of external assistance for health to India culled out from two successive UNDP Reports for 1994 and 1995 (Table 11, and 15). One distinct feature however remains time, namely the share of external assistance for health in total external assistance has shown some increase over time.

Table 15: Summary of External Assistance for Health Sector and Sub-sector

('000 US dollor)

Sub-sector: Health	1990	1991	1992	1993	1994	1995
Sector Policy and Planning	31,391	18,084	33,443	20,538	104,474	53,365
		(-42)	(85)	(-39)	-409	(-46)
Primary Health Care	42,156	66,163	83,851	49,882	112,628	64,591
		(57)	(27)	(-41)	(126)	(-43)
Immunisation and Other disease	94,147	51,420	69,430	77,204	105,467	127,202
Control Campaign		(-45)	(35)	(11)	(37)	(21)
Family Planning	10,979	13,700	15,734	4,984	7,104	14,468
		(25)	(15)	(-68)	(43)	(104)
Hospital and Clinics	5637	2,929	2,308	254	8,338	733
		(-48)	(-21)	(-89)	(3183)	(-91)
Total	184,310	152,296	204,766	152,862	338,011	263,359
		(-17)	(34)	(-25)	(121)	(22)
Grand Total of all sectors	1,257,343	3,140,406	4,457,349	2,453,963	2,305,674	2,429,038
		(-150)	(42)	(-45)	(-6)	(5)
% of Health to Total	15	5	5	6	15	11

Note: Figures in parentheses represents change over the previous years
Source: *India: Development Cooperation Report* 1994 and 1995.

External Assistance to NGOs

Before concluding this section, it may be useful to provide an idea of the external funds received by the NGOs for the health sector. Table 16 taken from Hirway and Chauhan (2000) shows that nearly 10–11 per cent of the total external funds provided to the NGOs are for the health sector. These funds are largely devoted to capacity building, education, and the training of the NGOs. According to the analysis carried out by Hirway and Chauhan, these funds which originated mostly from the US and Europe, have created a foreign element in the functioning of NGOs in India which according to them was not good for the NGO movement in India. It is also worth noting that the magnitude of foreign funds provided to the NGOs for the health sector is not insignificant (for instance over Rs. 300 crores in 1997–98 for the health sector excluding water and sanitation).

Table 16: Foreign Funding to NGOs (in Rs crores)

Year	NGOs in Health & Family Welfare Sector	All NGOs	Percentage
1987	54.45	491.68	11.07
1988	66.39	623.19	10.65
1992-93	131.36	1584.30	8.29
1993-94	122.26	1865.70	6.55
1994-95	169.35	1892.43	8.95
1995-96	162.07	2168.85	7.47
1996-97	284.57	2571.60	11.07
1997-98	306.52	2864.51	10.70

Sources: Computed from Hirway and Chauhan (2000), Table 2.

III

Impact Analysis: The Case of World Bank/IDA Assistance

Since 1972 the World Bank has provided assistance to 23 major health projects. The total assistance during 1972 to 1996 adds up to nearly USD 2.6 billion. The detail of this assistance has already been discussed in the preceding section (see Table 7). In the following discussion we attempt to summarise the nature and impact of such assistance in four major health sub-sectors.

1. Family Welfare Programme: Initially the Bank funded five population projects during 1972–88 with the aim of accelerating service delivery networks. However, the investment had little impact on outcomes as the Bank had little leverage due to the small size of assistance towards infrastructure. The other reasons were neglect of other non-infrastructural inputs, rigid delivery module, and untrained staff with poor supervision and recurrent budget constraints. During the post 1988 period, with rectification of earlier problems and substantially increased funding, three population projects got implemented. These projects were better designed and there was greater involvement of local people in execution. Greater emphasis was put on underlying sociological, political, and institutional factors in achieving the performance at the local level. The strategy was revised considerably by putting emphasis on outreach, on temporary methods *vis-à-vis* sterilisation, increased attention on MCH, enhanced quality of service delivery, training, and IEC, and focus on critical geographical areas. This time the impact on major outcome indicators was more discernible but income, education, and cultural factors continued to have an edge over service delivery factors in explaining health outcomes.

2. Nutrition Programme: The Bank has also provided support to nutrition programmes (TINP and ICDS). TINP, an innovative programme, was better designed with greater involvement of international, national, and local consultants as well as grassroot workers than the ICDS *per se*. As a result the TINP has shown significant impact in reducing severe malnutrition. The TINP model, which worked well but

unfortunately instead of being replicated, it has been abandoned, mainly because of the large costs associated with the TINP model.

3. Disease Control Programmes: Since 1992 the Bank also supported five disease control projects (leprosy, cataract blindness, TB, malaria, and AIDS) with the introduction of new treatment protocols and greater involvement of the private and NGO sector. Also, these projects were managed and monitored through district health societies that received funds directly from the Centre instead being channelled through various state level health departments (Gupta and Gumber 1999). The evaluation suggests a significantly rapid decline in the prevalence of leprosy and cataract blindness than would otherwise have occurred, an increase in the pace of detection and treatment of tuberculosis, substantial improvement in the safety of blood transfusions, and modest improvements in protective behaviour among select high-risk population groups. Somehow the strategy did not succeed in demonstrating visible impacts in slowing the AIDS epidemic and bringing down the incidence of malaria. Quite likely, the control of these epidemics require much more intensive efforts in changing the behaviour of individuals and population groups than in the case of leprosy, blindness, and TB control.

4. State Health System Projects: Till now the Bank has provided assistance to seven states to implement the State Health System (SHS) projects. These states are Andhra Pradesh (SHS-I); Karnataka, Punjab and West Bengal (SHS-II); Orissa and Maharashtra (SHS-III); and more recently Uttar Pradesh (SHS-IV). The objective is to influence the more fundamental and specific determinants of the health system at the state level as the state shoulders the major responsibility in the provision of health services. The SHS-I focused on improving secondary hospitals and the establishment of an adequate referral system between primary and secondary institutions in Andhra Pradesh. The other projects are extending the principles of the first but in some cases adding more work at the primary level. In all the projects the emphasis was also put on the development of physical infrastructure and enhancing the provision of drugs and other supplies at the PHCs and CHCs to address the needs of rural population. The project mid-term evaluations suggest some optimistic results in regard to accessibility,

service delivery, quality of services, efficiency, and financial autonomy of secondary hospitals.

To sum up, there has been a paradigm shift in the Bank assistance to the health sector after 1988. The shift is from small-assisted, no free-standing, supply-oriented, and supportive-nature projects to policy-oriented, capacity-building, and sector work thrust projects which are expected to have long lasting impacts and be sustainable. During the 1990s sector work has flourished and raised policy issues that are being taken seriously, health projects have been added to the portfolio, serious efforts have been made to shift focus from merely family planning to more towards MCH and RCH, contraceptive targeting was dropped, and health and state system reform projects have proliferated. New approaches are developed and initiated, including need based client centred approach in the delivery of family welfare services. Other initiatives recently taken by the World Bank include cost-effective interventions in disease control, decentralisation, greater involvement of grassroots NGOs and local community, financial management and expenditure control mechanisms, user charges and cost recovery and management of revenues, performance-based allocation mechanism, accountability and training of personnel and IEC. Except for greater involvement of private sector and NGOs, the Bank to a larger extent has succeeded in implementing and achieving the desired objectives.

IV

Assessing Externally Assisted projects

In this section we examine the resources needed in the design, formulation, and implementation of projects with external assistance. In this analysis we rely largely on the staff appraisal reports and implementation/project completion reports of some of the health projects supported by IDA funds. For this we consider the Child Survival and Safe Motherhood Project (CSSM) for which the credit closed on 30 September 1996. Table 17A provides an idea about the various steps involved in a World Bank supported project.

Table 17A: Project Timetable: CSSM Project

Steps in Project Life Cycle	Date
Depart Preparation Mission	November 27, 1990
Depart Appraisal Mission	April 17, 1991
Start Credit Negotiations	August 14, 1991
Board Approval	September 17, 1991
Credit Signing	February 20, 1992
Credit Effectiveness	March 5, 1992
Original Closing Date	September 30, 1995
Revised Closing Date	September 30, 1996

Source: World Bank, *Implementation Completion Report: CSSM.*

For instance, Table 17A shows that the time taken from preparation mission to the credit becoming effective is about 15 months. Even after the Board approval it took nearly 6 months for the project to become effective.

The other significant aspect in the implementation of a project is the extent to which the schedule of credit disbursement is adhered to. Table 17B gives an idea of the gap between the appraisal estimates and actual disbursements over the project cycle.

Table 17B: CSSM Project Credit Disbursements: Cumulative, Estimated and Actual (US$ Millions)

	FY 92	FY 93	FY 94	FY 95	FY 96	FY97
SAR Appraisal Estimate	46.20	93.60	151.40	207.40	214.50	214.50
Actual	29.40	46.79	83.97	153.46	209.02	234.54
Actual as Percentage of Estimate	64	50	55	74	97	109

Note: The credit was fully reimbursed (100 per cent in SDR terms) on December 1996.
Source: Staff Appraisal Report.

Table 17B clearly brings out the tardy utilisation of funds. In the initial stages the fund utilisation was from about 50 per cent to 75 per cent. This suggests the need for proper advance planning before beginning to implement the project.[1]

Similar picture emerges when we consider other projects funded by the World Bank for which we are able to obtain Implementation Completion Reports (ICR). These projects are: TINPII, ICDS I, and IPP VII. From the data provided in Tables 18, 19, and 20 we observe that it takes nearly two years for a project to become effective from the time that the process of identification of project begins. Further, it is seen that the time schedule for disbursement of funds as envisaged at the appraisal stage is seldom realised. This calls for better planning taking into account the capacity of governments to be able to stick to the prescribed time schedule for spending the funds.

[1] It would be useful to refer to Table A1 to see the tardy utilisation of funds. In most projects the intended disbursements as on date have been lower than the ones projected at appraisal stage. This trend is also indicated when we compare the intended disbursements with the revised ones.

Table 18A: Project Time Table: Second Tamil Nadu Integrated Nutrition Project

Steps in Project Cycle	**Date**
Identification (Executive Project Summary)	April 26, 1988
Preparation	November 1, 1989
Appraisal	January 12, 1990
Negotiations	May 4, 1990
Board Presentations	June 14, 1990
Signing	September 14, 1990
Effectiveness	December 5, 1990
Midterm Review (if applicable)	October 29, 1996
Loan Closing	December 31, 1997

Table 18B: Credit Disbursements: Cumulative Estimated And Actual (TINP II)

(US$ Million)

	FY 91	**FY 92**	**FY 93**	**FY94**	**FY 95**	**FY 96**	**FY 97**	**FY 98**
Appraisal Estimate	4.00	6.00	15.30	31.40	57.40	77.90	93.20	95.80
Formally *Revised					36.93	51.90	63.90	65.82
Actual	6.24	8.48	14.73	25.70	41.73	53.58	69.39	72.80
Actual as % of Estimate	156	141	96	82	113	103	108	111
Date of Final Disbursement: January 1998								

*Credit in the amount of US$ 32.3 equivalent was cancelled

Table 19A: Integrated Child Development Services (ICDS I) Project

Project Timetable

Steps in Project Cycle	Date Actual / Latest Estimate
Identification (Executive Project Summary)	April 26, 1988
Appraisal	January 12, 1990
Negotiations	May 8, 1990
Board Presentation	September 4, 1990
Signing	October 23, 1990
Effectiveness	January 28, 1991
Mid–term Review (if applicable)	January 8, 1997
Credit Closing	December 31, 1997

Table 19B: Integrated Child Development Services (ICDS I) Project

Credit Disbursements: Cumulative Estimated and Actual

(US$ Millions)

	FY 91	FY 92	FY 93	FY 94	FY 95	FY 96	FY 97	FY 98
Appraisal Estimate	5.00	10.50	24.70	44.00	64.60	83.20	100.20	106.00
Revised*					51.00	67.00	73.00	74.35
Actual	5.64	15.77	18.97	27.56	38.98	47.43	58.74	80.57
Actual as % Estimate	113	150	77	63	60	57	59	76
Date of final disbursement	April 24 1998							

*Credit in the amount of US $ 23.5 million equivalent was canceled on May 1, 1993

Table 20A: Seventh Population Target

Project Time Table

Steps in Project Cycle	Date Actual / Latest Estimate
Preparation	October 1, 1989
Depart Appraisal	January 12, 1990
Negotiations	April 11, 1990
Board Presentation	May 17, 1990
Signing	October 23, 1990
Effectiveness	March 8, 1991
Mid-term Review (if applicable)	March 31, 1997
Credit Closing	June 30, 1997

Table 20B: Credit Disbursements: Cumulative, Estimated and Actual

Credit Disbursements: Cumulative Estimated and Actual (US $ Millions)

	FY 91	FY 92	FY 93	FY 94	FY 95	FY 96	FY 97	FY 98	FY 99
Appraisal estimate	3.11	16.42	38.6	60.95	87.51	87.51	93.01	96.70	
Revised estimate after cancellation of exchange rate of savings	9.84	12.66	22.30	34.97	43.53	47.03	56.03	63.03	63.95
Actual	9.84	11.55	19.30	32.37	38.87	50.98	61.09	68.57	
Actual as % appraised estimate	316	70	50	53	50	58	66	70	
Actual as % of revised estimate	100	91	87	83	89	100	100	100	100

It would now be interesting to obtain an idea about the resources devoted to comply with the project requirements. Table 21 gives the necessary details

Table 21: Resources to comply with Project Requirements

	Actual	
	Weeks	**'000 US$**
Preparation to Appraisal	67.5	127.6
Appraisal	98.5	185.8
Negotiations through Board Approval	6.5	12.0
Supervision	191.4	360.8
Completion	8.00	2.2
Total	371.9	688.4

Table 21 refers to the CSSM Project. It is seen that supervision followed by appraisal operations, which constitute the backbone of a project, take most time and financial resources.

V

Summarising: Overall Assessment and Lessons Learnt

The preceding discussion has shown that in the initial stage, most funds from external sources were aimed at family welfare and population control programmes. Moreover, until about the early 1980s most external assistance was from bilateral donors with the US contributing the most. However later, from the mid-1980s, the multilateral donors, particularly the World Bank became the single largest donor of funds for the health sector. Also, the initial phase of external assistance for health witnessed a passive role of the donors, in the sense that these donors had little influence in shaping or influencing in any great measure the health policies of the country.

However, with the World Bank becoming a major donor of funds, the situation changed. While the focus on population and reproductive health was not lost, the Bank with some other donors, particularly the USAID and UNICEF gave attention to child health through supporting nutrition programmes for the child. Towards the close of the 1980–90 decade and subsequently, both bilateral and multilateral donors entered the health sector. Particular attention was paid to supporting various disease control programmes such as tuberculosis, leprosy, malaria, HIV/AIDS, and cataract blindness. As pointed out, the decade 1990–2000 saw the launching of a series of State Health System Projects in several states with a view to strengthening the referral system through providing critical inputs to secondary level health care facilities. The post 1985 period, particularly after the 1990s is also marked by a more active participation of donor community in the design of various health interventions. The decentralisation approach, the setting up of societies to overcome flow of funds problems, and the adoption of target free approach are some of the key developments of the post-1990 period. Another major development witnessed during the post 1990 period, especially around the time RCH project was being negotiated, was the fostering of effective donor co-ordination. While it is difficult to assess at this stage the impact of better donor coordination, it is clear that it was urgently needed to avoid overlapping of assistance. It is also likely to contribute to both transparency and accountability as far as external assistance is concerned. The

external assistance in the health sector has also resulted in greater involvement of the NGO community in the sector work. This has been largely possible due to some kind of implied preferences of the donor community to assign an increasing role to the NGOs. The other significant donor driven development is the promotion of the concept of user charges and increased involvement of the private sector in areas where publicly provided health care services are particularly deficient.

The above summarising clearly reveals that over the period the extent of external assistance for health sector has shown a secular rise and that the role of donors has gradually changed from being passive actors and has become one of active participant. Also in the past decade, the health policies have undergone many changes, some which have been influenced by donors. It may in conclusion however be pertinent to point out that external assistance has not in any way reduced either the Union government's or the state governments' commitment to the health sector as determined by the level of official funds made available to the sector.

Before concluding this section in may be useful to give in brief the major strengths, weaknesses, opportunities, and threats (SWOT) associated with external assistance. This is followed by a brief outline of the problems, which the donors generally experience in providing funds to India.

SWOT Analysis: There are several inherent advantages which are associated with external assistance especially for countries, which are deficient in resources—financial and technical. However, there are also some problems in relying too heavily on donor funds. Table 21 lists some of strengths and weakness of our dependence on donor funds for the health sector. *Inter alia* opportunities and threats associated with donor funds are indicated.

Table 21: SWOT Analysis of External Assistance

Strength	**Weakness**	**Opportunities**	**Threat**
Bring in expertise (technical), experience of other countries and resources which national government need. Catalytic to certain fundamental policy reforms Enhance management and project management capacity Transfer of best practices Increases transparency and accountability Enhances competition Controversial and unprecedented (sensitive) projects can only be undertaken with external assistance Develop local capacity	Lack of ownership Affect adversely innovation Unless national governments are careful they may create greater dependance Can miss social and cultural context in the areas of transferring practices, approaches, concepts (STIs/HIV/AIDS) Risk of corruption Bypass normal channels of working Sustainability is a major issue. (polio eradication can collapse if funding is withdrawn)	Enabler funding Develop local capacity Learning cost reduces leading to LEFROG (ing) Enables bench-mark comparisons	Distort national priority Risk of input of inferior/non-deliverable technologies and concepts Hidden agenda (most donors have long term effect in mind-where as we have short view Donors tend to replace the responsibility of national government Dictated mostly by international policies/developmental policies Long-term indebtedness keeps increasing Programme and technical assistance find way back to donor countries

As is evident from the SWOT analysis there are both positive and negative facets of external assistance. Some of these are indicated below:

- Most projects have questionable sustainability.
- Most projects are vertically down projects with little change in users' perception.
- Most projects are not based on user needs.
- Most projects have lacked holistic approach. A majority of the projects are fragmented, e.g. RCH, PPI, and HIV/AIDS to take a few have features which overlap.
- Most programmes designed under the external assistance are based on symptomatic treatment rather than identifying the root causes.
- Enhanced level capacities- PM, MIES, M&E
- Enhanced awareness in political/ bureaucratic decision-makers.
- Better international standard awareness.
- Limited reforms more towards involvement of NGOs/CSOs/ privatisation/ unbundling.

Concluding Remarks

Most donor agencies — multilateral and bilateral — set aside a certain portion of their funds for providing financial and technical assistance to various developing and poor countries. Apart from governments and international agencies, funds are raised outside the government system mainly by the NGOs for charity purposes. Both donors and other organisations providing such assistance are accountable to their respective governments/agencies or communities from whom they raise funds. Thus donors carry the mandate of their governments, i.e. the purposes for which funds are to be utilized. While in principle this is true, in practice however there is a lack of clarity on the part of

both donors and recipient governments in regard to the purposes for which funds are needed. For instance, a national government is tempted to accept an offer, say of some equipment offered by donors, without articulating the need for such help. Also, perhaps, out of sheer expediency, these are accepted without due regard to issues of their maintenance costs and other recurrent expenditures. Clearly such opportunistic aid serves little purpose as other parameters which are critical to the utility of such aid are seldom analysed. Similarly, because of limitations on funds, small pilot projects (focussing on one or two narrow aspects of the problem) are initiated. Clearly in such an exercise the broader objectives may get side tracked.

Another problem in the donor-supported projects is adherence to the prescribed time schedule. Normally donor funds have to be spent within the time limits prescribed or agreed upon, and according to well-defined agreed budget lines. There is very little flexibility available with the donors for rescheduling budget lines, etc. The donors also have a genuine problem in granting extensions. These arise from the fact that as long as the project is not cleared, and ongoing, donors have to incur substantial costs in the form of their staff and other related resources. Thus donors are uncomfortable in granting extensions.

In addition to these problems, time and cost overruns also tend to distort the stated objectives of the projects. Thus extensions do not find favour with donor governments. National governments, because of various factors and poor implementation capacity, usually delay the execution of most projects. They seldom realise the need for timely execution of projects. They should understand that most projects are resource intensive, e.g. the project staff cannot be dispensed with until the completion of the project. This entails extra cost besides keeping the personnel occupied with some work.

There is, however, now an increasing realisation about the need to work in a different way, such that resources are used in a sustainable way. This is possible when funds flow faster. This will be helpful to both donors and national governments. This is

being currently done by the donors who help the national governments through Inter Agency Coordination Committee mechanism.

It may, in conclusion, be useful to indicate some of the problems that the donors experience in providing assistance to India.

- Population, Diversity and Bureaucracy, three major problem
- Lack of clearly articulated policies and strategies (private, NGOs, etc.)
- Political commitment
- Legal structure
- Accountability
- Federal system needs to be implemented as most decisions taken centrally.
- Decentralisation needs to be strengthened
- Transparency: how things happen
- Enabling environment to fund state, private sector and NGOs lacking

The discussion so far brings in focus some lessons in ensuring efficient utilisation of external assistance taking into account the national policies and priorities.

- It is useful to have governments, which understand its priorities. The real problem, however, arises when we have a weak national government.

- A government that understands its role in regard to the need for bringing external funds, and that these funds are well spent so that it is able to create a change within the system for its own benefit — improve its own functioning as well as its efficiency.

- Governments should realize that external funds are not forever (in the case of NTCP (TB), supervisors were appointed from done funds — once these funds are over then what? Also an embargo is put on any recruitment of TB. Question is that in such cases, supervisors cannot be appointed from CSSM (Project) of Leprosy staff, for instance, once they become redundant, they

were re-employed as Laboratory Assistants. Clearly for such decisions, we require a strong government.

- Government should learn to work with donors in partnership, and elements of suspicions harboured by donors and national government alike should stop.
- Clearly the responsibility lies both with national governments and donors.
- The realization that resources are finite and donors are keen to ensure that resources are being used properly by the national governments, and that they are getting full value for their money. They also need to ensure that their national priorities are being cut at work in partnership.
- Expanded scope of activities needed greater modifications in programme strategy than were adopted. CSSM added UIP plus and EOC to UIP but did not either centralize operations sufficiently or put in place an enhanced programme management capacity.
- A country-wide programme requires a well functioning MIES.
- Systematic management training should be a major concern. It should be broad based.

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TABLE A1: Statement of Loans

Financial Year	Borrower	Purpose	Original Amount (US$ millions)				Difference between Actual and Expected Disbursement	
			IBRD	IDA	Cancel	Undisb	Original	From Revised
1999	India	2nd National HIV/AIDS Co	0.0	189.36	0.0	184.47	2.82	0.0
1995	India	Ap 1st Ref.Health S	0.0	122.22	0.0	53.26	18.64	0.0
1993	India	ICDS II (Bihar and MP)	0.0	190.81	0.0	112.08	113.08	107.09
1992	India	Maharashtra health system	0.0	119.79	16.0	26.09	42.0	25.29
1992	India	Malaria Control	153.0	156.58	0.0	120.26	96.0	27.8
1992	India	National Leprosy Eliminia	485.0	0.0	35.0	125.32	160.32	0.0
1996	India	Orissa Health System	350.0	0.0	0.0	309.0	151.5	0.0
1994	India	Population IX	0.0	84.31	0.0	47.0	27.2	0.0
1992	India	Population VIII	0.0	77.59	0.0	50.21	50.9	0.0
1997	India	Reproductive Health	0.0	241.37	0.0	203.16	73.9	12.87
1996	India	State Health System II	0.0	317.34	0.0	230.87	140.51	0.0
1997	India	Tuberculosis	0.0	132.32	0.0	127.49	70.4	0.0

Source: Compiled from Staff Appraisal Report of the World Bank.