

# **PROJECT IMPLEMENTATION PLAN FOR VULNERABLE GROUPS UNDER RCH II:**

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**Government of India  
Department of Family Welfare  
Ministry of Health & Family Welfare**

This document covers:

- (i) PIP for Vulnerable Groups (in general)
- (ii) PIP for Tribal Health
- (iii) PIP for Urban Slum Health

**PROJECT IMPLEMENTATION PLAN**  
**VULNERABLE COMMUNITIES INCLUDING SC/ST**

## **BACKGROUND**

Vulnerable communities include those groups who are underserved due to problems of geographical access, (even in better off States) and those who suffer social and economic disadvantages such as Scheduled Castes/Scheduled Tribes (SCs/STs) and the urban poor. Scheduled Caste people (166.6 million) and Scheduled Tribe people (84.3 million) in India are considered to be socially and economically the most disadvantaged group. Scheduled Castes constitute 16.2% and Scheduled Tribe 8.2% of the country's population (as per the 2001 Census). Their percentages in the population and numbers however vary from State to State. Scheduled Castes and Scheduled Tribes do not live only in homogeneous communities, but are found within heterogeneous communities both in rural and urban areas. There are six predominantly tribal States/UTs (Arunchal Pradesh, Meghalaya, Mizoram, Nagaland, Dadar and Nagar Haveli and Lakshdweep) where more than 60% of the population is tribal and another 9 States (Andhra Pradesh, Assam, Jharkhand, Gujarat, Chhattisgarh, Maharashtra, Orissa and West Bengal) where majority of tribal people live. Scheduled Caste population is spread over in all the States and UTs. However, in the States of Arunchal Pradesh, Nagaland, Manipur, Mizoram and Goa, the SC population is less than 3%. The RCH indicators for slum population are worse than the urban average. Marginalization results in poorer social indicators for these groups, including maternal and child health indicators. This can be as much a result of service provider behaviour as of health seeking behaviour and capabilities.

## **BASELINE DATA ON TRIBAL AND SC POPULATION**

The NFHS II survey provides information on the status of SCs and STs as compared to rest of the population for a number of RCH indicators that are relevant to the Millenium Development Goals. A comparative statement under different RCH components for scheduled caste and scheduled tribes against the rest of the population is given below: -

Health Indicator	Scheduled Castes	Scheduled Tribes	Rest of Population
IMR	83.0	84.2	61.8
Under 5 Mortality	119.3	126.6	82.6
TFR	3.15	3.06	2.66
% Children underweight	53.5	55.9	41.1
Children with anaemia	78.3	79.8	72.7
% children with ARI (prev 2/52)	19.6	22.4	18.7
% Children with diarrhoea (prev 2/52)	19.8	21.1	19.1
% Women with anaemia	56.0	64.9	47.6

(Sources NFHS – 1998-99)

## **2. RATIONAL FOR VULNERABLE COMMUNITIES REPRODUCTIVE AND CHILD HEALTH PLAN UNDER RCH-II.**

### 2.1.1 *Demand-Side Barriers to Accessing Services:*

- Poor connectivity to health centers because of distance, topography, and lack of public transport;
- Location disadvantage of sub-centres, PHCs, CHCs.
- Social and cultural barriers especially for women.
- Lack of suitable transport facility for quick referral of emergency cases.

### 2.1.2 *Structural constraints*

- Lack of flexibility and reduced responsiveness to local diversity and needs;
- Scarcity of funds for non-salary expenditure including innovative activities;

### 2.1.3 *Human resource management weaknesses*

- Lack of appropriate Human Resource Development (HRD) Policy to encourage/motivate the service providers to work in remote and tribal areas.
- Poor work environments and dissatisfaction amongst the workforce;
- Understaffing of remote or even semi-remote facilities;
- Weak monitoring and supervision systems.

2.2 RCH-II seeks to address the above issues systematically. The Vulnerable Communities Health Plan for the RCH-II programme adds value by acting as a “conscience” within the Department of Family Welfare to ensure that RCH-II is progressively more focused on reaching those least served, and by earmarking a separate pool of resources that will enable innovative solutions to be implemented – in monitoring systems; in Behavioral Change Communication, service delivery, Public-Private Partnerships, demand-side financing, such as insurance and voucher schemes, training and supervision of professional, auxiliary and administrative staff, research on tribal systems of medicine, planning capacities, disseminating good practice, etc.

## **3. GOALS AND OBJECTIVES:**

**Goals:** To improve health status of vulnerable population by ensuring accessibility and availability of quality primary health care and family welfare services to them.

**Objective:** The overall objective of the Vulnerable Plan is to: (i) improve accessibility, availability and acceptability of health services including RCH services by strengthening infrastructure including training and skill development of service providers, improving supply of equipment, drugs etc in an integrated and participatory manner and (ii) to bring them at par in this respect with rest of the population, and thus improving the aggregate indicators towards achieving the expected results set under RCH Phase II by the end of 2010.

#### **4. STRATEGY**

- In the first year of RCH II, the States will identify the vulnerable groups and include in their PIPs a strategy to prioritize vulnerable groups (what will be done to improve their health status and how it will be done). They will also develop a Monitoring and Evaluation mechanism to assure this. The capacity needs will also be reflected to effectively develop and implement the strategy.
- The State PIP will show that resource allocations have been prioritized towards vulnerable groups.
- The behavioral communication strategy developed for RCH will take into account the specific needs of the vulnerable groups.
- States and Districts have flexibility to prepare their plans to respond to the needs of vulnerable groups.
- There would be convergence of health activities with those of other departments such as ICDS and Water and Sanitation. Private Sector and NGOs will also give priority to vulnerable communities and supplement/complement the efforts of Government Departments.
- RCH II also has a Performance Fund that will grant additional funds to States / districts that provide evidence of significant improved performance. The majority of indicators for success will be based on quality and convergence of services to the vulnerable.
- In the first three years, performance indicators will be mostly process indicators that show that the state is addressing comprehensively the problem of improving services to the vulnerable. In the later years of the Programme, output and outcome indicators will be used to show the benefits received by vulnerable communities.

- Consultation and participation: Elected representatives of panchayati raj institutions at various levels will be involved in planning, implementation and monitoring. They will also participate in mobilizing resources, involve communities and create enabling environment. The States will also involve health service providers, professional associations, faith based organizations, NGOs, women self help groups, total literacy campaign groups and cooperative groups. Committees will be formed at village level (including Gram Pradhan, ANM, AWW, Link workers and two members of the Gram Sabha. Similar committees may be formed at Block level and district level.

## **5. HEALTH PLAN FOR VULNERABLE GROUPS**

- 5.1.1 A special Health Plan for tribals living in notified Tribal Blocks (having more than 50% Tribal Population) will be prepared by the State Governments in accordance with PIP for Tribal Health (**Annexure I**). The PIP for Tribal Health gives details as to how the Health Plans are to be prepared, the funding pattern, interventions envisaged etc. It also mentions special budget of Rs. 688 Crores.
- 3.1 A Health Plan for tribals living in urban and rural areas (not covered by Tribal blocks) is required to be prepared as part of the district plan in accordance with the strategies given in PIP Tribal Health.
- 3.2 A Health Plan for slum dwellers in urban areas will be prepared in accordance with PIP for Urban Slum Health (**Annexure-II**). Urban Slum Health Projects are required to be prepared for cities / towns having population of more than one lakh. The PIP for Urban Health incorporates guidelines for preparation of urban slums Health Projects, funding pattern, interventions envisaged etc. It also mentions that Rs. 700 Crores (now reduced to Rs. 350 Crores) are earmarked for Urban Slum Health in Xth Plan. In smaller towns, the requisite focused interventions for urban poor including slum dwellers may be incorporated in the District plan.
- 3.3 Health Plan for other vulnerable communities such as SCs/STs and the poor living in urban and rural areas (not covered by Urban and Tribal Projects) may be prepared as a part of district health plan.

Every State and District Plan will identify the vulnerable communities in both rural and urban areas, and address their needs, increase their access to the quality health

services. All data will be consistently disaggregated by SC/ST and by gender. It is therefore, necessary that monitoring and evaluation procedures / formats must indicate the extent of utilization of services by the SC/ST and other vulnerable groups as identified in the district plan, and their outcomes.

## **5. WORK PLAN**

State Governments may designate an officer (e.g. Project Director RCH or any other Officer) who will be responsible for identification of Tribal Blocks for preparation of Tribal Health Plan for the identified tribal blocks. Similarly, District RCH Officer may be made responsible for inclusion of Tribal component in the District plans.

State Governments will prioritize the cities for preparation of Urban Slum Health Projects by involving the local municipality. An Officer will be designated who will be responsible for preparation of the Projects, implementation and monitoring of the Projects. At the city level, an officer shall be designated as city project coordinator for implementing the Project.

District RCH Officer will be responsible for inclusion of vulnerable communities in the District Plan, its implementation and monitoring.

At the National level, Deputy Commissioner (ID), Department of Family Welfare will be the nodal officer for Vulnerable Communities projects including Urban Slum Health Projects and Tribal Health Projects and will coordinate with the National Health Resource Centres and the State Governments.

## **6. NATIONAL HEALTH RESOURCE CENTRE**

It is proposed to set up a National Health Resource Centre at New Delhi. The National Health Resource Centre will have a unit for promoting best practices in addressing the needs of the vulnerable, carry out needs analysis, design services and their management and monitoring. States may seek, if needed, technical assistance from NHRC to strengthen their efforts to improve the health status of the vulnerables.

## **7. COVERAGE**

The schedule for coverage is laid down in the PIPs for Urban slums and Tribal areas. For cities/towns having less than one lakh population, Urban Slum Health Projects are not required to be prepared. All such cities / towns will be covered in the District Plans to provide services to the urban poor from the first year of RCH-II. Similarly in rural areas, the District Plans will incorporate provisions to provide focused attention to SC/ST and other vulnerable groups from the first year of RCH II.

## **8. MONITORING AND EVALUATION (M&E)**

The programme will improve the Monitoring & Evaluation of services in relation to vulnerable groups in order to track progress by producing regular, timely and quality data. The data will be analyzed and made publicly available in order to improve accountability for expenditure and staff performance. Annual reviews of RCH II, as a whole, ought to focus in each State on the processes and performance of service delivery for the vulnerable. By June 2005, common MIS and reporting formats (providing for dis-aggregation of data by Block/SC/ST and gender-wise, will be ready). This system will be piloted in the poorest districts of each State during 2005. Public access to key areas of disaggregated Block Level MIS data (financial and service provision) would be made available from 2006. The NHR Centre will monitor the performance up to the State level. The States will monitor availability of quality services to Vulnerable population including those who are underserved due to problems of geographical access, (even in better off States) and those who suffer social and economic disadvantages such as SCs/STs and the urban poor up to district level. The districts will monitor performance at CHCs/PHCs and Sub-Centres level. Indicators will not be based on services functioning, but on measures of access by the vulnerable to those services.

### **Examples of Process Indicators**

- Percentage of districts having identified vulnerable groups and having these groups included in their PIPs.
- Percentage of districts having conducted consultation process with the stakeholders.
- Percentage of districts having conducted facility survey and mapping up of available infrastructure and manpower etc.
- Percentage of districts, which have identified and nominated officers for implementation and monitoring of project.
- Percentage of districts having identified training institutions, number of raining courses conducted and training institutions identified for strengthening.
- Percentage of districts having developed dependable referral system.
- Number of states having developed suitable manpower policy for serving in the tribal/remote areas.



**Output Indicators :**

- Percentage of vulnerable groups utilizing the facilities.
- Percentage of Ante-Natal/Post Natal coverage from vulnerable groups as compared to the rest of the population.
- Percentage of deliveries conducted by skilled providers (doctors, nurses, ANMs) among the vulnerable groups as compared to rest of the population.
- Percentage of institutional deliveries among the vulnerable groups.
- Percentage of children (1-6 months of age) from vulnerable groups visited by any health provider within a week of birth.
- Percentages of children among vulnerable groups fully immunized-age group-wise.
- Percentage increases in respect of access to and demand of essential RCH services including demand and supply of contraceptives among the vulnerable groups.
- Number of training programmes for community workers, medical and para medical staff and extent of involvement of community in the project formulation, implementation and monitoring and evaluation.
- Involvement of NGOs including outsourcing of services/institutions to private sector for attending obstetric emergencies.
- Number of cases provided transport facilities in cases of emergencies including obstetric emergencies.
- Status of submission of progress reports including Statement of Expenditure and Audit Reports at agreed intervals.

(The above indicators are only indicative. For detailed indicators, please refer to the Manual of guidelines for preparation of District Action Policy.)

Revised Draft  
Project Implementation Plan – Tribal Health

Background

Tribal people (about 84 million) in India are considered to be socio-economically the most disadvantaged group. They constitute 8.2% of the country's total population. Their numbers, however, vary from State to State. The tribal development strategy of Government of India is based on the twin approach of protection of interests of tribal people through legislative and administrative support and promotion of development efforts through plan schemes. As far as the health sector is concerned, the National Population Policy 2000 has made special mention of tribal areas in terms of improving basic health and reproductive and child health (RCH) services. The National Population Policy 2000 places RCH at the centre stage and the immediate objective is to address the unmet needs of health infrastructure, train health care personnel and contraception. One of the themes spelt out in the NPP relates to addressing the unserved/underserved areas with a focus on tribal areas.

1.2 Tribal communities of India cannot be clubbed together as one homogeneous group. They belong to different ethno-lingual groups, profess diverse faith and are at varied/different levels of development- economically, educationally and culturally. There are more than 400 tribal groups in the country of which 75 are primitive tribes characterized by declining/static/low growth rate. There are 6 predominantly tribal states/UTs (Arunachal Pradesh, Meghalaya, Mizoram, Nagaland, Dadra and Nagar Haveli and Lakshadweep) where more than 50% population is tribal and another 9 states (A.P. Assam, Jharkhand, Gujarat, Chattisgarh, Maharashtra, Orissa, Rajasthan and West Bengal) where majority of Schedules Tribes (ST) population lives.

2. Rationale for Tribal Health Component under RCH (II).

Tribals have poor access to health services and there is also under utilization of health services owing to social, cultural and economic factors. Demand side barrier structural constraints, HRD issues and the provider attitudes are particularly acute in tribal areas. A comparative statement of different RCH indicators for the SCs/STs against the rest of the population is given below.

Health Indicator	Scheduled Castes	Scheduled Tribes	Rest of Population
IMR	83.0	84.2	61.8
Under 5 Mortality	119.3	126.6	82.6
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(Source-NFHS-1998-99)

### **Magnitude of Health problems in tribal areas**

- Decadal Growth rate of ST population is reported to be higher than that of the total population
- Percentage of girls marrying below 18 years in many Tribal districts is up to 60.
- 43.1% of tribal pregnant women do not receive any antenatal check up, 38.7% do not receive any Tetanus toxoid injections and only 48.6% were given Iron and Folic acid tablets.
- 8 1.1 % tribal pregnant women deliver at home, 44.4 % of all deliveries are attended by TBA and 32.2% by other untrained persons.
- Only 14.1% have any postnatal check up within 2 months of birth.
- Unmet need for family planning 15.4%
- 42% of currently married women have any reproductive health problem
- High prevalence of falciparum malaria, Tuberculosis, sickle cell disease, 0-6 PD deficiency, etc. also add to the problem.
- Infant mortality is higher in the tribes as compared to non tribes.
- 79.8% of tribal children are anemic.
- Only 26% of children receive all vaccines.
- 55% of children belonging to Scheduled tribes were underweight

(Source: NFHS II).

Some of the problems of accessibility and poor utilization of health services unique to tribal areas are because of:

- Difficult terrain and sparsely distributed tribal population in forests and hilly regions.
- Locational disadvantage of sub-centers, PHCs, CHCs.
- Non availability of service providers due to vacant posts and lack of residential facilities.
- Lack of suitable transport facility for quick referral of emergency cases.
- Lack of appropriate HRD policy to encourage/motivate the service providers to work in tribal areas.
- Inadequate mobilization of NGOs.
- Lack of integration with other health programs and other development sectors.
- IEC activities not tuned to the tribal: idioms, beliefs and practices.
- Services not being client friendly in terms of timing, cultural barriers inhibiting utilization.
- Non involvement of the local traditional faith healers.
- Weak monitoring and supervision systems.

### **3. Goal & Objectives of the Program:**

**Goal:** To improve the health status of the tribal community by provision of need-based quality integrated primary health and family welfare services with a view to achieve the socio demographic goals envisaged under National Population Policy 2002.

**Objective:** The main objective of the program is to develop integrated and sustainable system for primary health care services delivery in the tribal areas of the country. Primary Health Care services, in this context, will include the National Programmes like Family Welfare/ RCH and the National Disease Control Programmes as well as curative and referral services in coordination with the ongoing health & Family Welfare Programmes, along with associated supplies, management and information to both users and providers.

### **3.1 Strategy: To attain the above goals and objectives, the strategy will be to:**

- Assess the unmet needs of RCH services in different tribal areas and different tribes.
- Provide integrated and quality RCH Services
- Improve service coverage, accessibility, acceptability and its utilization.
- Promote community participation and inter-sectoral coordination.
- Promote and encourage tribal system of medicine.
- Develop a sufficient number of first referral institutions capable of tackling emergencies including obstetric emergencies.
- Provide associated supplies, management and information.

### **3.2 Human Resource Development:**

The State Governments may consider suitable incentives to the health service providers to ensure availability of required manpower in the Tribal Areas. The States may also consider providing ANM training to the tribal girls by relaxing educational standards (if feasible), without linking the said training to job. Expenditure on such training may be charged to the project.

### **4. Program Description:**

**As a part of the program, the support will be provided for implementation of tribal health projects in the identified areas as per the following:-**

#### **Coverage:**

The program would be implemented in a phased manner. Considering the importance and need for providing services to scheduled tribe population, it is proposed to cover all the tribal blocks (numbering around 600) having 50% or more tribal population, with priority to blocks having Primitive Tribal Groups (PTGs). Keeping in view the likely availability of funds for Tribal Health Program under RCH-II, the following year-wise phasing of tribal blocks is proposed

Year	I	II	III	IV	V	Total
Proposed Block coverage	100	120	120	120	140	600

For the notified ITDP's/ITDA's, the program will be implemented through their administrative set up. All blocks having notified tribal areas, where RCH/HFW programmes are already under implementation, will be covered in the first Phase of the Project.

### **5. Service delivery model:**

- Under the ongoing program of the Ministry of Health & Family Welfare, a three-tier Primary Health Care system is already functioning in all States/UTs.(Norms for tribal areas however differ from norms in non-tribal areas). It is proposed to strengthen the existing service delivery model by supplementing with (i) grassroots level support for service provision and engagement & training of social workers/link volunteers/ASHA (preferably a literate woman from the community) who could maintain link between health facility and the community. NGOs and Private Sector through Public-Private

Partnership should also be involved in the provision of Primary Health Care Services and also as part of the referral system. .

5.2. In order to increase utilization of health services by the tribal population some of the innovative approaches that need to be addressed are involving the community in the planning process, as well as in the management and implementation of various programs; using Community Based Workers both men and women from the community as social mobilizer, educator and provider of non clinical services; involvement of local elected bodies including Tribal boards; and promotion of tribal system of medicine, and tribal healers to be part of the health team. In addition, service delivery through mobile vans should also be used wherever needed.

## 6. Type of Services :

There is an essential package of RCH services that are being provided under the RCH program. This package would be appropriate for tribal areas as well. An area that needs priority is promoting better nutrition considering a high magnitude of macronutrient and micronutrient deficiencies, which are major link in intergenerational transmission of poverty. In addition, in the Tribal Health Project there should be special emphasis on diseases like malaria, tuberculosis, Yaws, Sickle cell anemia, Thalassemia G-6PD deficiency etc. The specific services will vary based on the needs of the area. The type of services to be provided at various levels is summarized as under:-

<b>Tier</b>	<b>Service</b>
<b>Community Level</b>	<b>Community based worker /ASHA to work as social mobiliser, educator &amp; provider of non-clinical services and to work as Depot holder for contraceptives. To act as DOTs provider for the revised National TB Control Program, to take malaria slides, store and distribute anti-malaria drugs, create awareness about sanitation, safe drinking water and participate in the other health care programs.</b>
<b>Sub Centre</b>	<b>ANC&amp;PNC services, IFA distribution, delivery by skilled attendant, referral for institutional delivery, contraceptive distribution and referral for terminal methods, immunization, management of childhood illness, deworming, nutrition and health education for mothers, treatment of minor ailments including RTI/STI, services under national programme like DOTS, NMCP, counseling services.</b>
<b>PHC</b>	<b>All above + dispense ayurvedic, homeopathic, Unani and Tribal system of medicines.</b>
<b>Block PHC/CHC</b>	<b>All above+Terminal method of FP EOC+ elective abortion 1<sup>st</sup> Trimester, MVA, screening and clinical based services for sickle cell anaemia, Thalassemia, G-6 PD deficiency and Lab services.</b>

## **7. Support/inputs to be funded under the program:**

The financial support and interventions will depend upon the specific proposals received from the State Governments to meet the outlined objectives of providing integrated Primary Health Care & FW Services in tribal areas. Some of the interventions to be considered for financial support under the programme are summarized as under:-

- Institutional Strengthening to put in place a strong management structure for efficient implementation of the project by MOHFW.
- Support to infrastructure and service delivery in the public sector to fill in gaps and make the services more user friendly. Supplement the public sector service delivery by engaging the private sector at all levels, more so at the community level.
- Manpower development by way of better recruitment, training and rewards systems. An existing private sector organization can be identified for providing support on training and manpower development.
- Training and working with ISMPs and tribal system of medicine practitioners.
- Developing a need based and culturally sensitive Communication program
- Integration with other departments to promote better resource utilization
- Operations Research to identify alternative strategies to improve tribal health
- Development of referral system for institutional deliveries, emergency obstetric care and terminal method of family planning.
- Service delivery through mobile vans to sparsely distributed tribal population.
- Involve NGOs/Private Sector in the provision of Primary Health Care Services and also as part of the referral system.
- Reorganizing and restructuring of the existing service delivery infrastructure to become an integral part of the proposed system
- Provide and encourage tribal system of medicine.

### **7.2 Community level**

The Program envisages provision of a community based female link worker/ASHA from the community to work as social mobiliser, educator and provider of non-clinical services including depot holder for contraceptives. The link worker should be a woman from the village, who is able to spare 3-4 hours a day. She will be selected by the PRI and the ANM and trained by the PHC/NGO. She will work with AWW under the guidance and supervision of the ANM/PRI. The link worker may be paid honorarium of Rs. 500/- p.m. (Rs.400 from the project+Rs.100 from the State Government funds for ensuring sustainability after the project is over). The payment of honorarium should be linked to some minimum performance criterion to be decided by the State Government. The possible support areas are:

- Identification of link volunteers and their training
- Provision of contraceptives like condoms and pills and other drugs etc. such as ORS, IFA tablets for outreach services.
- Provision of other items as per the services to be provided by link volunteers.
- Provision of honorarium.
- Provision of training component including refresher training, wherever necessary.

### **7.3 Sub-Centre Level**

- Renovation/upgradation of the existing facilities including addition of staff quarters for ANM where necessary.
- Renting of accommodation for establishing new sub-centres.
- Equipment & furniture for services to be provided from sub-centre to be ascertained through facility survey.
- Need based drugs and supplies including ISM/Tribal/Homeopathic medicines etc.

### **7.4 PHC**

- Renovation/upgradation of the existing facilities including addition of staff quarters wherever necessary.
- Recurring maintenance cost to be provided for upkeep of the unit and equipment to the BMO.
- Renting of accommodation for establishing new PHCs.
- Equipment & furniture for services to be provided from PHCs to be ascertained through facility survey.
- Need based drugs and supplies including ISM/Tribal medicines.
- Mobility support either through provision of vehicle or hired vehicle for referral services.
- Support for additional manpower on contractual basis only after re-deployment of the existing staff.
- RCH Camps/Couple Melas/Innovative approaches
- Additional need based training (not covered under other programmes) to medical/para medical staff.

### **7.5 CHC/Block PHC**

- Renovation/upgradation of the existing facilities including addition of staff quarters wherever necessary.
- Recurring maintenance cost to be provided for upkeep of the unit and equipment to the BMO.
- Support for need based additional labs/indoor facilities.
- Equipment & furniture for services to be provided from CHCs to be ascertained through facility survey.
- Support for local contractual arrangements for specialist/part-time specialist medical officers.
- Mobility support either through provision of vehicle or hired vehicle for referral services.
- Support for additional manpower on contractual basis only after re-deployment of the existing staff.
- Need based drugs and supplies including ISM/Tribal medicines.
- Additional need based training (not covered under other programmes) to medical/para medical staff.

## **8. Public Private Partnership**

Successful implementation of the project will require a vibrant partnership between the GOI (DOFW) and State Government. While the DoFW will provide technical assistance, the State government will provide leadership to the project facilitating ground implementation. The private sector can be fruitfully engaged for service delivery to fill in gaps. The donor agencies can provide technical assistance to the program by sharing experience across the globe in tribal health development and facilitate program design. The main specific interventions envisaged for support under the program are as under:-

- NGOs mapping should be carried out in the tribal areas and credible NGOs especially with clinical services backup should be encouraged to take the total responsibility of managing the RCH and health services in the sub-centre/PHC/CHC where public health system is deficient/inadequate.
- NGOs and corporate sectors should be encouraged to take up CBD projects covering minimum a block population and could coordinate mobile health services, counseling, referral transport, awareness creation and social mobilization.
- NGOs and private nursing homes/hospitals may be involved in the program including service delivery through a frame work of partnership.
- Accreditation methods can be followed for private and NGO operated facilities. All facilities within the framework should follow uniform reporting system and referral system.
- Outsourcing/franchising of discrete services (such as diagnostics) to NGOs/Private Sectors.

## **9. Work plan**

Under the program, the States are required to prioritize the tribal areas by doing facility mapping and baseline survey of indicators in identified areas. Based upon this, the State Governments may prepare project proposals for Tribal Areas in consultation with the tribal community and send to GOI for consideration and financial support. While doing so the State must ensure that the tribal health programs supported by any other donor agency/NGOs are also taken into account to ensure that there is no duplication of efforts in the same area and the projects outside the purview of this program are also consistent with the overall objective and strategies of this program and convergence of the services. The work plan showing the main activities to be undertaken at the national & State level is given below:

### **9.1 National level**

- Preparation of guidelines & Terms of Reference for the program.
- Request for proposal from the concerned States.
- Evaluation of the proposal for financial support.
- Physical and Financial Monitoring of the program.
- Provision of financial/technical support to States in formulation of the project proposals. Stat Governments may seek financial assistance for preparation of Tribal Projects through Technical Agencies/Consultants, if required.



## 9.2 State level

- Prioritization of the areas to be covered under the program.
- Need assessment including mapping of all existing health services run by public sector and private sector including non-profit organizations to prevent duplication.
- Existing government facilities in the project area to be integrated by up gradation/ relocation/ reorganization/ closure.
- Identification of the agencies for formulation of the proposal.
- Submission of the proposal to the Government of India.
- Setting up of technical support unit for monitoring the implementation of the projects.
- Scrutiny and approval of the district plans

## 9.3 District level

- Needs assessment, including mapping of all existing health services run by public sector and private sector including non-profit organizations.
- Baseline survey, other surveys as needed
- Preparation of Plans
- Implementation of the plans and regular dialogue with the State level, particularly in the matter of policy and managerial support needed.
- Submission of regular monitoring and service reports.
- Full accountability for attainment of the agreed objectives.

### **Funding Pattern**

#### **Fund flow mechanism:**

Flow of funds for the RCH project in tribal areas will be similar to the present funds flow mechanism. From GOI the funds will be released to state SCOVAs. SCOVA will release the funds to the district society/Zilla Panchayat. If there is a single State/ District Health & FW society, a separate account has to be opened for the RCH project in tribal areas. The District society in turn will release funds to the Block PHC MO/ Block Panchayat.

#### **Cost:**

On the basis of the projects providing similar types of services in some of the projects under implementation, it is estimated that a sum of Rs.30 lakhs per block per year would be required for the tribal projects. This is based on the presumption that approximately 1,50,000 population would be covered in each of the tribal blocks. Per capita expenditure of Rs.20 is estimated to be spent on Tribal Health interventions. In addition, at the sub center imprest money of Rs.1000.00, for non-allopathic medicines are likely to increase the project cost. In view of this, the cost per block per year for population of 1.5 lacs has been taken at Rs.40 lakhs.

#### **Year-wise allocation.**

A sum of Rupees 115 crores has been earmarked for Tribal Health Program under the RCH II. This allocation is over and above the budget earmarked for taking up activities covered under other schemes of RCH-II in Tribal areas. Additional funds will also be available out of the 10% of the budget earmarked for NE States for taking up activities in areas in North-Eastern States covered under this program. Keeping in view the average cost of Rs.40 lacs per block per year and coverage of all 600 blocks over a period of 5

year, the year wise proposed allocation is estimated at Rs.680 crores as per the following details:-

<b>Year</b>	<b>I</b>	<b>II</b>	<b>III</b>	<b>IV</b>	<b>V</b>	<b>Total</b>
<b>Proposed Block coverage</b>	<b>100</b>	<b>120</b>	<b>120</b>	<b>120</b>	<b>140</b>	<b>600</b>
<b>Proposed outlay (Rs. In crores)</b>	<b>40</b>	<b>88</b>	<b>136</b>	<b>184</b>	<b>240</b>	<b>688</b>

### **Sustainability**

The support under the program will be limited to the project implementation period of RCH-II Program. It, therefore, becomes imperative that all the project proposals should have a detailed plan of action for sustaining the program after the GOI funding comes to an end. This detail plan of action should address the issue of cost recovery, cost sharing and cost reduction. Pooling of resources, convergence, ownership and commitments of ICDS, Tribal Welfare Board, Departments of Civil Supplies, Rural Development, Panchayati Raj and Education of the State and Central Governments will ensure sustainability. Introduction of user fees depending on the socio-economic condition of Tribal people may be considered in later stages of the programme.

### **Monitoring & Evaluation**

The program will be closely monitored at National, State, district and village level and also need to be evaluated from time to time. The monitoring will not be restricted to physical and financial achievements but will also include the following:

- Comparison of the Baseline and end line, process & impact indicators will allow project results and achievements to be measured.
- Regular monitoring on the basis of service data.
- Committees will be constituted at the Central, State, District and village levels and the donor agencies for review.
- Performance monitoring to be consistent with CNA.
- Concurrent evaluations by independent agencies.

### **Integration with other Departments**

Inter-sectoral linkages of various agencies involved in the tribal development need to be encouraged. Efforts should be made to integrate with other departments like Forest, Education, and Rural Development for the delivery of services, especially where Public health care facilities are inadequate. Projects with integration with other departments should be encouraged.

### **Operations Research**

- a. Alternative strategies to improve accessibility and utilization of health/RCH services in tribal areas.
- b. Improving skilled attendance in MCH care with special reference to deliveries.

# Project Implementation Plan – Urban Health

## Background

With the increasing urbanization and growth of slums and low income population in the cities, the provision of assured and credible primary health services of acceptable quality has emerged as a priority thrust area for both the central and the State Governments. The need has arisen due to the fact that the focus till now has been on development of a rural health system having three tier health delivery structure. While on the other hand, no specific efforts have been made to create a well organized health service delivery structure in urban areas especially for poor people living in slums. The emerging importance of the problem can be gauged from the fact that whereas the total population has grown 3 times in last 50 years, the urban population has grown by 4.5 times during the same period (from 62 million to 285 million - 2001 censuses) and today constitutes about 27.78% of total population. Also the growth rate is far higher today for urban population (3.16%) than for total population (2.16%). Within urban areas the growth rate is highest for urban slums. Recognizing the seriousness of the problem, the Government of India has identified “Urban Health” as one of the thrust area in the Tenth Five Year Plan, National Population Policy 2000, National Health Policy 2002 and the forthcoming 2<sup>d</sup> Phase of the Reproductive Child Health Program.

A tentative provision of Rs.700 crores is earmarked for urban health program under RCH-II Program.

## Goal & Objectives of the Program:

*Goal:* To improve the health status of the urban poor community by provision of quality integrated Primary Health Care Services.

*Objective:* The main objective of the program is to provide integrated and sustainable system for primary health care services delivery in the urban areas of the country, with focus on urban poor living in slums and other health vulnerable groups. To attain this, the specific objectives will be :

1. To strengthen the existing urban health infrastructure by renovation/upgradation of existing facilities.
2. Provision of establishing new facilities in uncovered urban slums areas.
3. To support the development of a referral system for institutional deliveries, emergency obstetric care and terminal method of family planning.
4. Involvement of the NGOs/Private Sector in the provision of Primary Health Care Services and also as part of the referral system.
5. Integration of the existing health infrastructure with the proposed urban health program.

## Program Description

As a part of the program, the support will be provided for implementation of urban health projects in the identified cities as per the following:-

**Coverage:**

The program would be implemented in a phased manner in all the states with priority being accorded to EAG and Northeastern states. The latest 2001 census reveal that there are 423 towns/cities having a population of more than 1 lac. Of these 423 cities, 28 cities are having population of more than 10 lacs. Keeping in view the type of urban health infrastructure already available in these cities and the ongoing facilities/programs already under implementation in big cities by various agencies viz. State Government, Municipal Corporation, Pvt. Nursing Homes/Hospitals, NGOs, etc. the proposed urban health program will focus on cities having population between 1-10 lacs (numbering 395 as per the 2001 census). Of the 395 cities, having population between 1-10 lac, it is proposed to cover these cities in the phased manner as per the following:-

<b>Year</b>	<b>I</b>	<b>II</b>	<b>III</b>	<b>IV</b>	<b>IV</b>	<b>Total</b>
No. of cities to be covered	50	75	100	125	45	395

The above phasing of coverage of cities has been made keeping in view the allocation of Rs.700 crores available for Urban Health Program under RCH-II for a period of 5 years.

Depending upon the availability of funds the support to big cities having a population of more than 10 lacs population will be restricted to bringing improvement in the quality of services. . Other components to be need based and considered on case by case basis. List of the cities having population > 1 lac is enclosed at Annex-I.

**Service delivery model:**

Under the ongoing program of the Ministry of Health & Family Welfare, different types of urban family welfare centres (UFWCs)and urban health posts (UHPs) are already functioning in different States/UTs. The Government of India is supporting 1083 UFWCs, 871 UHPs, 3239 beds under sterilization beds scheme. The post Partum centres (550 at district level and 1012 at sub-district level) supported till 2002 by GOI are now being funded by the State Governments with additional support from Planning Commission. The State-wise details are annexed. In addition, the other facilities run by State Governments/Municipalities/NGOs/Private Sector are also available to provide Primary Health Care Services in urban area. In view of the different nomenclatures and types of facilities, the program envisages implementation of a uniform service delivery model by upgrading/strengthening of the above infrastructure, integration of the facilities run by State Governments/municipalities and other private agencies and establishing new facilities. The proposed two Tier service delivery model envisaged under the program is as under:-

**I Tier:**

Urban Health Centre (1 for 50000 population) with the following proposed staff

Medical Officer (LMO)	- 1
ANMs	- 3-4 @ 12000-15000 population
Lab assistant	- 1
PHN/LHV	- 1
Staff/clerk	- 1
Chowkidar	- 1
Peon	- 1

To develop and maintain a link between health facility and the community, the program envisages engagement of social community workers/link volunteers, preferably in the age group 25-35, a female from the community able to spare 3-4 hours a day acceptable to the community, preferably to be engaged through local NGOs. The need for volunteers would be reassessed periodically. Possibilities should be explored to phase them out over the life of the project so as to make the system self-sufficient after the completion of the project period.

Prerequisites:

1. Efforts should be made to redeploy the existing staff from the existing facilities, wherever possible.
2. The new staff will need to be appointed through contractual appointment.
3. Existing service delivery system will be reorganized and restructured to serve a defined geographical area for a defined population. The new facilities to be established to serve the remaining area or target population.
4. ANM should be given an identified area for outreach services.

**II Tier**

**Referral Hospital (City /District Hospital/Maternity Home/Private & NGO Nursing Homes/Hospitals**

The support envisages strengthening of existing centres with public-private partnership, recognition of private nursing homes/hospitals to provide the pre-determined services & mobile support for floating/migrating population/temporary slums/construction workers. .

**Type of Services**

The I Tier Health Centre will provide only the outdoor services. The complicated referral cases and indoor services will be available only at the II Tier viz. Referral Institutions. The details of the service provision at these two levels is as under:-

**I Tier Health Centre:** Antenatal care, Postnatal care, Referral for institutional deliveries, Immunization, Services under national programs like DOTS, NMCP Etc., Family planning including IUD, NSV & referral for terminal methods Lab services Treatment of minor ailments including RTI/STI Depot holder services for contraceptive and ORS , Promoters/Education and help ANMs for outreach services through social community/link volunteers.

Support activities like -

Demand generation through targeted IEC  
Training

**II Tier Referral Centre:** Institutional delivery  
Emergency obstetric care  
Terminal methods of family planning  
2<sup>nd</sup> Tier curative services for RTI/STI

## Support/inputs to be funded under the program

The financial support and interventions will depend upon the specific proposals received from the State Governments to meet the outlined objective of providing integrated Primary Health Care & FW Services in urban areas. However, the main activities/interventions to be considered for financial support to become an integral part of such proposals are summarized as under:-

### I Tier Health Centre:

- Renovation/upgradation of existing facilities
- Renting of accommodation for establishing new Urban Health Centres. This facility will include provision of space for services, office, minor OTs, Lab and store room for equipments etc. besides patient waiting area.
- No new construction will be supported under the program.
- Equipments & furniture for services to be provide from the urban health centre (to be ascertained through a facility survey for the existing facility and as per the standard list for the new facilities to be established)
- Support for additional manpower on contractual basis only after redeployment of the existing staff.
- Needs based drugs & supplies (excluding supplies being made under other programs/schemes)
- Mobility support (hired vehicle for referral services)
- A support for services to be provided by NGOs will be considered on similar pattern as per specific agreement reached.

### II Tier Referral Centre:

- Renovation/upgradation of existing referral facilities
- Support for need additional add on lab/indoor facilities .
- Equipments & furniture for services to be provide from the referral centres (to be ascertained through a facility survey for the existing referral facilities)
- Support for local contractual arrangements for specialist/part time Specialist medical officer.
- Needs based drugs & supplies (excluding supplies being made under other programs/schemes)
- A support for services to be provided by NGOs will be considered on similar pattern as per specific agreement reached.

## Public Private Partnership

Successful implementation of the project will require a vibrant partnership between the DoFW, GOI, State Government and the Urban Local Bodies. While the DoFW will provide technical assistance, the State government will provide leadership to the project facilitating ground implementation by the Urban Local Bodies. The private sector can be fruitfully engages for service delivery to fill in gaps. The donor agencies can provide technical assistance to the program by sharing experience across the globe in urban health development and facilitate program design. The main specific interventions envisaged for support under the program are as under:-

- NGOs and private nursing homes/hospitals may be involved in the program including service delivery through a frame work of partnership.

- Accreditation methods can be followed for private and NGO operated facilities. All facilities within the framework should follow uniform reporting system and referral system.
- Outsourcing/franchising of discrete services (such as diagnostics) to NGOs/Private Sectors.

## Work plan

Under the program, the States are required to prioritize the cities by doing facility mapping and baseline survey of indicators in identified cities. Based upon this, the proposals for the respective cities will come to Government of India for consideration of financial support. While doing so, the States must ensure that the urban health programs supported by any other donor agency/NGOs are also taken into account to ensure that there is no duplication of efforts in the same area and the projects outside the purview of this program are also consistent with the overall objective and strategies of this program and convergence of the services. The work plan showing the main activities to be undertaken at the national & State level is given below:

### National level

- Preparation of guidelines & Terms of Reference for the program.
- Request for proposal from the concerned States.
- Evaluation of the proposal for financial support.
- Physical and Financial Monitoring of the program.

### State level

- Prioritization of the cities to be covered under the program.
- Need assessment including mapping of all existing health services run by public sector and private sector including non-profit organizations to prevent duplication.
- Existing government facilities in the project area to be integrated by up gradation/ relocation/ reorganization/ closure.
- Identification of the agencies for formulation of the proposal.
- Submission of the proposal to the Government of India.

*After the approval of the proposal the main activities to be undertaken by the States are as under:-*

- Setting up of Technical Support Unit in State Directorates.
- Capacity building and reorientation of key officials of state and urban local bodies.
- Constitution of a state level empowered committee and monitoring committees to approve plan of action and monitor implementation respectively.
- Project Management Units will be set up in ULB, including management consultant depending on city population and mechanism of service delivery.
- Undertake IEC and procurement activities.
- Contracting out of services to private sector.
- Identification of link-volunteers, CBOs/ grassroots organizations.
- Training will be conducted under RCH as for rural areas.
- Focused capacity building of community volunteers on Behavioral Change Communication methods.

## Funding Pattern

- Funds flow will be from GOI to State Government/State level society for further transfer of funds to the implementing agency.
- Funding support would be provided for a maximum period of 5 years starting from the beginning of RCH-II.

- The ongoing urban health projects under implementation in the identified cities will be integrated and will become an integral part of overall urban health program.

## Cost

As regards the costing of a Health Centre, the indicative costs of inputs based upon the IPP-VIII experience are as follows:-

### Personnel Cost

I .Category of Personnel (Each health centre)	No. of post Sanctioned	Recurrent/ Capital	Monthly Exp.	Annual Expenditure
1) Lady Medical Officer	1	Recurrent/	12600/-pm	1,51,200-00
2) LHV/PHN	1	Recurrent/	6,500/-pm	78,000-00
3) ANM's	3	Recurrent/	5,500/-pm	1,98,000-00
4) Link workers	10	Recurrent/	500/-pm	60,000-00
5) Security Guard @ Rs: 5000/- PM		Recurrent/	4,000/-pm	48,000-00
6) Clerk	1	Recurrent/	5,000/- pm	60,000-00
II . Annual maintenance of equipments, Furniture etc.,Each health centre		Recurrent/		10,000-00
III Electrical, Water, Building Charges etc.,		Recurrent/		50,000-00
IV . Building Maintenance charges (Repair & Painting)		Recurrent/		1,00,000-00
V . Drugs		Recurrent/		30,000-00
VI . Training		Recurrent/		1,00,000-00
VII . IEC materials		Recurrent/		10,000-00
VIII Hiring of Vehicles		Recurrent		1,75,000-00
<b>GRAND TOTAL</b>		Recurrent/		<b>10,70,200-00</b>

### Equipments & Furniture

Equipments		Non recurrent		10,00,000-00
Furniture		Non recurrent		1,00,000-00
Grand Total				21,70,200-00

**The cost for renovation & upgradation of the existing facility into a Health Centre will in the range of Rs.2-3 lakhs. The rent for a new facility will cost around Rs.1,00,000/- to Rs.2,00,000/- per annum. As regards the costing of services to be provided at the referral centre and through public-private partnership, the costing would depend upon the specific interventions to be supported and the agreement reached with the private institutions.**

**Based upon the above costing, it is imperative that in the subsequent years of the project implementation, the recurring liability will be a major portion of the cost to be met out of the budget provision to be kept in that particular year.**



## **Year-wise allocation**

**A tentative allocation of Rs.700 crores is earmarked for Urban Health Program under RCH Program for a period of 5 years. Based upon the proposals received, it is estimated that a medium sized town may cost around Rs.3 crores for a period of 5 years. Keeping in view this average cost and the proposed phasing out of coverage of 395 cities over a period of 5 years, the year-wise proposed allocation is as under: -**

<b>Year</b>	<b>I</b>	<b>II</b>	<b>III</b>	<b>IV</b>	<b>IV</b>	<b>Total</b>
Proposed outlay (Rupees in crores)	30	75	135	210	250	700

## **Sustainability**

**The support under the program will be limited to the project implementation period of RCH-II Program. It therefore, becomes imperative that all the project proposals should have a detailed plan of action for sustaining the program after the GOI funding comes to an end. This detail plan of action should address the issue of cost recovery, cost sharing and user fee.**

## **Monitoring & Evaluation**

The program will be closely monitored at National, State & City level and also need to be evaluated from time to time. For this purpose a Committee will be constituted at the state level with GOI and donor agencies for review. The monitoring will not be restricted to physical and financial achievements but will also include the following:-

- Comparison of the Baseline and end line, process & impact indicators will allow project results and achievements to be measured.
- Regular monitoring on the basis of service data.
- Performance monitoring to be consistent with CNA.
- Concurrent evaluations by independent agencies.