Preface

The country has initiated the RCH Phase II program as scheduled from 1 April, 2005. This program implies a "paradigm shift" looking upfront at performance and upholding the desired standards of quality and client sensitivity.

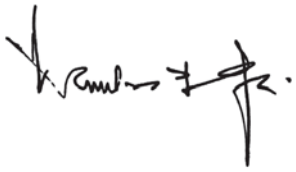
This program evolves a shared vision and a common program encompassing the entire Family Welfare sector, lending a strong focus on results, especially improving the use of RCH services by the poorest and the underserved populations and thereby contributing to the national and international goals. This takes into account needs as identified in the district plans and available capacities. This program also allows states to have greater flexibility to use the allocated funds and enhance accountability to results by allocating a part of the funds to the achievement of agreed results especially among the poorest. At the same time, use of innovative approaches and enhancing the participation of the private and the NGO sector are hallmarks of this program.

This program was designed in a process of extended and intensive consultation with the states, development partners, NGOs, experts and other stakeholders.

This intense effort will be tested against the changes perceived in service delivery, improved performance and ownership at decentralized levels in times to come.

The efforts of all those who contributed to this process, especially the design team led by Dr N Chatterjee of WHO and her colleagues, is acknowledged with appreciation.

We hope this National Plan for RCH Phase II will provide guidance to all stakeholders and implementers of this process. This, however, is an evolving document and will be enriched in due course especially in its association as an integral part of the National Rural Health Mission.



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National Program Implementation Plan
RCH Phase II - Program Document

Document 1: Policy Framework

Introduction

This document is **Document 1** of the Reproductive and Child Health Phase II Program documentation. It gives a summary and overview of the policy context in which RCH Phase II has been designed, its strategic direction, the lessons from RCH Phase I, and the institutional and financial arrangements.

Document 2 describes the principles and evidence base that underpins the strategic decisions and priorities of RCH Phase II.

Document 3 is the National Level RCH Phase II Program Logical Framework.

These three documents are necessary summaries and more detail is provided by the following **RCH Phase II supporting documents** (based on detailed studies and available in electronic form).

SD1	Background Document
SD2	Good Practices
SD3	Public Expenditure Review
SD4	Performance Based Financing for RCH Phase II
SD5	Demand Side Financing
SD6	Adolescent Health
SD7	Immunization MYP
SD8	Urban Health for RCH Phase II
SD9	Tribal Health for RCH Phase II
SD10	Gender
SD11	Equity and Access
SD12	BCC in RCH Phase II
SD13	The Demand and Supply Nexus
SD14	Public Private Partnerships for RCH Phase II
SD15	MIES for RCH Phase II
SD16	Inter-sectoral Convergence in RCH Phase II

For the sake of brevity, most references have been removed, but these remain in the supporting documents.

Abbreviations

AD Syringes	Auto Disabled Syringes
AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Care
ANM	Auxiliary Nurse Mid-wife
ARI	Acute Respiratory Infection
ASHA	Accredited Social Health Activist
AWP	Annual Work Plan
AWW	Anganwadi Worker
BCC	Behavior Change Communication
BPL	Below Poverty Line
CBO	Community-Based Organization
CHC	Community Health Center
CINI	Child In Need Institute
CNAA	Community Needs Assessment Approach
CNAMA	Community Needs Assessment and Monitoring Approach
COC	Combined Contraceptive Pill
CPR	Contraceptive Prevalence Rate
DEMO	District Education and Media Officer
DFID	Department for International Development
DHA	District Health Authority
DLHS	District Level Household Survey
DoH&FW	Department of Health & Family Welfare
DP	Development Partners
DSF	Demand Side Financing
EAG	Empowered Action Group*
EC	European Commission
ECTA	European Commission Technical Advisory
EmOC	Emergency Obstetric Care
FMG	Finance Management Group
FP	Family Planning

* This is a group of eight states, namely, Uttar Pradesh, Uttaranchal, Bihar, Rajasthan, Orissa, Madhya Pradesh, Jharkhand and Chattisgarh which is a subset of NRHM special focus states.

FRUs	First Referral Units
GDP	Gross Domestic Product
GIA	Grants-in-Aid
GoI	Government of India
HIV	Human Immunodeficiency Virus
HRG	High Risk Group
HR	Human Resources
ICC	Institutional Co-operation Component
ICDS	Integrated Child Development Services
IFA	Iron and Folic Acid
IMNCI	Integrated Management of Neonatal and Childhood Illness
IMR	Infant Mortality Rate
IUCD	Intra Uterine Contraceptive Device
IUD	Intra Uterine Device
JSK	Janaswasthya Sthirtha Kosh
JCWG	Joint Consultative Working Group
LHV	Lady Health Visitor
LV	Link Volunteer
M&E	Monitoring and Evaluation
MBB	Marginal Budgeting for Bottlenecks
MMR	Maternal Mortality Rate
MO	Medical Officers
MoH	Ministry of Health
MoH&FW	Ministry of Health and Family Welfare
MoU	Memorandum of Understanding
MTP	Medical Termination of Pregnancy
NACP	National AIDS Control Program
NFHS	National Family Health Survey
NGO	Non-Governmental Organization
NIHFW	National Institute of Health and Family Welfare
NNMR	Neonatal Mortality Rate
NPP	National Population Policy
NRHM	National Rural Health Mission
Obs/gyn	Obstetrics and Gynecology
ORS	Oral Rehydration Solution
PHC	Primary Health Center

PIP	Program Implementation Plan
PMG	Program Management Group
POP	Progesterone Only Pill
PPTCT	Prevention of Parent to Child Transmission
PRI	Panchayati Raj Institutions
PWD	Public Works Department
RBM	Results Based Management
RCH	Reproductive and Child Health
RET	Regional Evaluation Team
RHS	Rapid Household Survey
RKS	Rogi Kalyan Samiti,
RMP	Registered Medical Practitioner
RTI	Respiratory Tract Infection
SACS	State AIDS Control Society
SC	Sub Center
SCOVA	Standing Committee on Voluntary Action
SD	Standard Deviation
SHG	Self Help Group
SHI	Social Health Insurance
SIP	Sector Investment Program
SoE	Statement of Expenditure
SRH	Sexual and Reproductive Health
SRS	Sample Registration System
STDs	Sexually Transmitted Diseases
STI	Sexually Transmitted Infections
TBAs	Traditional Birth Attendants
TFR	Total Fertility Rate
ToR	Terms of Reference
TT	Tetanus Toxoid
ULB	Urban Local Body
UT	Utilization Certificate
VCTC	Voluntary Counseling and Testing Center
WB	World Bank
WHO	World Health Organization
ZSS	Zilla Saksharata Samiti

RCH PHASE II PROGRAM - DOCUMENT 1

1

Strategic Direction

1.1 Vision

The vision is to bring about outcomes as envisioned in the Millennium Development Goals, the National Population Policy 2000 (NPP 2000), the Tenth Plan document, the National Health Policy 2002 and Vision 2020 India, minimizing the regional variations in the areas of reproductive and child health and population stabilization through an integrated, focused, participatory program, meeting the unmet demands of the target population and provision of assured, equitable, responsive quality services.

The vision clearly brings out the fact that the RCH Phase II is viewed as a program and not as a project. A five year term for RCH Phase II (a period of five years 2005 -2010) is considered as a project for convenience. The focus of the RCH program will be on reducing the maternal mortality ratio, the infant mortality rate and total fertility rate. It also aims to increase the couple protection rate and the coverage of children through immunization. These are to be achieved through the provision of a common essential package of service delivery mechanisms to be implemented by the RCH program. The supply side strategies are to be oriented to the demand side sensitivities, to provide assured, equitable, responsive and quality services. The system would be shifted to gear itself up on a mission mode by using performance benchmarking and accountability tools.

The performance levels of the different states show variations ranging from very high levels to low levels of achievement. This has the effect of lowering the overall performance levels of the country as a whole. The reasons for the variations in performance are based in the deep-rooted socio-cultural and geographic features that are very peculiar to a country like India. To take into account the variations it has been realized that a 'one-size fit all' strategy may not suffice and hence a differential approach for a group of states at homogenous levels of achievements have been taken in the design of the program.

Based on the above vision statement for RCH, it is anticipated that the program would produce equitable maternal and child health outcomes, including family planning and contribute to raising the status of the girl child. The RCH Program has the following clearly articulated principles, consistent with the Tenth Plan and NPP goals that may guide all levels and all stages of planning and implementation:

RCH Program Principles:

- Improving health outcomes is a shared responsibility of providers, local governments, households and communities.
- There should be no discrimination in access to essential quality health services.
- The poorest have the right to get full value for the money being spent by the government or by themselves.
- Service providers should be responsible for outputs and outcomes, suitably empowered, and made accountable within the principle of subsidiary.
- Female children have an equal right to health, emergency medical aid, and to live with human dignity.
- The program would include voluntary and informed choices in administering family planning services. The responsibilities of the service providers would be clearly outlined with careful regard for human resources. Clear tasks would be laid out for service providers to provide quality services to meet unmet needs of family planning and spacing methods in desirable quantities.
- The strengths of public and private sectors should be harnessed to achieve the RCH program goals.
- The RCH program will protect people in accordance with the statutes.
- The RCH program efforts will consistently focus on the most vulnerable.

1.2 Goals

Indicator	Tenth Plan Goals (2002-2007)	RCH Phase II Goals (2005-10)	National Population Policy 2000 (By 2010)	Millennium Development Goals
Infant Mortality Rate	<45/1000	<30/1000	<30/1000	-
Under-5 Mortality Rate	-	-	-	Reduce by 2/3 from 1990 levels
Maternal Mortality Ratio	200/100000	<100/100000	<100/100000	Reduce by 3/4 by 2015
Total Fertility Rate	2.3	2.1	2.1	-

The immediate objective, as envisioned in the National Population Policy 2000 (NPP) is to address the unmet needs of contraception, health care infrastructure, health personnel and provide an integrated service delivery for basic reproductive and child health care, with special focus on states facing the biggest socio-demographic challenges.

The medium term objective outlined in the NPP 2000 is to bring the Total Fertility Rate (TFR) to replacement level by 2010, through coordinated implementation of the inter-sectoral linkages.

The long-term objective is to achieve a stable population by 2045, at a level consistent with the requirements of sustainable economic growth, social development and environmental protection.

Objectives:

More specifically, in the context of the Tenth Plan and NPP 2000 the objectives are to:

- Reduce the decadal rate of population growth between 2001 and 2011 to 16.2%
- Reduce IMR to < 45 per 1000 live births by 2007 and <30 per 1000 live births by 2010
- Reduce TFR to 2.1 by 2010
- Improve coverage of full Ante Natal Care (ANC) from 44.5% (RHS 2002-03) to 89% in 2010
- Improve coverage of institutional deliveries/safe deliveries from 39.8% /54.07% (RHS 2002-03) to 80% in 2010
- Improve coverage of fully immunized children from 48.2% (RHS 2002-03) to 100% in 2010
- Improve Contraceptive Prevalence Rate (CPR) from 44.8% (RHS 2002-03) to 65% in 2010
- Improve quality, coverage and effectiveness of the existing, FW and essential RCH services with special focus on the EAG states
- To improve management performance, establishing state ownership of the program and institutional strengthening at the center, state and districts levels for timely and coordinated utilization of project resources
- Concentrate on intensive development of human resources through the strengthening of institutions and enhancement of skills, complemented by an efficient support system to enhance the quality of monitoring and evaluation (M&E), procurement, financial management and service delivery
- Expand essential RCH services through the universalization of RCH in small and medium towns, as well as introduce a package of essential RCH services for the vulnerable groups

1.3 Policies

1.3.1 Sector level

- Bring about inter-sectoral collaboration through networking at the highest levels and then percolating to the different levels.
- To include public health as a specialization in the medical education curriculum in order to bring out trained public health managers to manage public health and bring in public health as a function.
- To revitalize the human resources policy and also address the career movement, posting and training issues.
- Open up primary health care to groups of professionals/individuals willing to take on such service provision functions, especially at the primary levels accompanied by appropriate governance mechanisms.
- Activating voluntary level societies/ community level workers for bringing in additional funds into the sector (ZSS, RKS+ JSK, ASHA).
- Address adolescent health as an important issue and develop packages for activating this aspect.
- Integrate with the ongoing National AIDS Control Program (NACP) and establish linkages with HIV prevention programs.
- Develop separate plans for dealing with the problems of vulnerable groups including a tribal action plan and an action plan for the urban poor.

1.3.2 Program level

- RCH is visualized as a program and not as a project
- Differential approach to cater to multiple situational requirements
- Professionalism through technical support/outsourcing/contracting/lateral infusions
- National program with a broad framework and inbuilt flexibilities to enable choice at the state levels
- An umbrella program encompassing the different requirements
- It would address access, equity, vulnerability and gender issues while taking into consideration the demand side requirements
- Professional public health managers to head all tiers
- Approach targeting essential package of services towards beneficiaries
- Involvement of private sector in provision of services

1.3.3 Sector reforms

- Functional and organizational review of the sector
- A cadre review and analysis growth progressions within the cadre
- Analysis of facilities, utilization, strengthening, relocations etc.
- Human resource management and planning, including HR policy reforms
- Key positions - providing continuity of leadership at different levels
- Induction of skilled professionals especially in the area of management and finance
- Involvement of PRIs and ULBs
- Village level link mechanisms
- Management structures to manage programs
- Capacity raising and linked to posting policies
- Pre-service and in-service training
- Tracking effectiveness of training
- Need and evidence based planning to address regional priorities
- Strengthen infrastructure after a comprehensive facility survey and creation of infrastructure based on potential load factor analysis
- Strengthen M&E by utilizing disaggregated data within states
- Monitoring and corrections based on performance indicators
- Adherence to comprehensive standards of quality assurance in service delivery

1.4 Strategic Framework

- Where health seeking is already high and there is a demand for services, the strategy would be to strengthen the quality of service delivery.
- Where knowledge and health seeking itself is not up to the desired levels, the priority would be to enhance knowledge, including skills and the provision of easily implemental approaches in order to demonstrate the utility and necessity for seeking and using services.
- Emphasis on a well-designed communication strategy covering a set of focused issues at different stages of the program's progress, depending upon the outcomes realized through communication.
- Enhance and expand the basic infrastructure where it is lacking.
- Phased expansion of activities.
- Skill building within the delivery systems, focusing on both technical and managerial capacity, associated with appropriate human resource policies and sufficiency in terms of numbers.
- Effective alternative methods of service delivery have to be addressed jointly/exclusively.
- Community mobilization mechanisms.
- A strong institutional base with built-in planning and monitoring systems to track progress and make mid-course corrections if necessary.
- To build procurement plans and systems to ensue availability.
- To provide a momentum that will set into motion the steps towards sustainable service delivery mechanisms.

1.4.1 Strategies to address the lessons from RCH Phase I

1.4.1.1 Flexibility: States' needs and capacities

Issues:

- A "one size fits all" approach to program design is not suitable
- Need to take into account state/district level requirements

Strategies:

- Planning will be based on the analysis of state level requirements as assessed from district level requirements
- Differential approach based on state specific scenarios
- Encourage and gather evidence for decentralized planning at the state level
- Plans to be prepared by states based on the overall guidelines provided by the national framework
- Special attention to states facing the biggest socio demographic challenges

1.4.1.2 Strengthening management capacity

Issues:

- Need for professionals with adequate program management skills
- Planning, monitoring, budgeting and resource allocation are to be considered critical in the program

- Frequent turnover (transfer and retirement)
- Need for result/outcome orientation
- Need for Human Resource (HR) planning
- Financial/accounting/disbursement and utilization bottlenecks

Strategies:

- Program management structures with provision for contracted lateral infusion of professionals
- Capacity building in program management
- Monitoring systems to be introduced
- Structures to provide for functional specification in planning etc
- Review and adoption of HR planning, transfer, promotion policy
- Infusion of qualified finance professionals and overhauling of the traditional accounting system to make it faster yet easier to monitor

1.4.1.3 Integrated Behavior Change Communication (BCC) strategies

Issues:

- BCC is currently very generic
- Need to introduce a focused and thematic approach
- Needs to be carried out as an activity with considerable potentials.

Strategies:

- Emphasis placed on development of a BCC strategy
- Overall national priorities and desired behavior change to guide the framing of the strategy
- Based on the national BCC strategy – states to adapt/adopt it to develop state specific objectives and strategies
- Emphasis on viewing BCC as a driver to change and adopting this to impact the drivers impacting on the outcomes
- Trained human resources and partnerships with NGO/CBO needed
- Linkages of the present IEC structures would be reckoned
- Tracking IEC input and output linkages for optimal utilization of the IEC resources
- Emphasis on increasing the health/life skill issues in the syllabus of elementary and secondary education
- Accessing all available channels for dissemination of 'Health Values', Hygiene, HIV/AIDS, 'No to Early Marriage', 'No to Gender Violence', 'No to Female Feticide'

1.4.1.4 Improved client responsiveness to public health facilities

Issues:

- Low utilization of public health facilities
- Complaints against insensitive providers

- Hidden costs incurred by users
- Clients have little choice between the expensive, inadequate private sector and the apathetic public sector providers.

Strategies:

- Reviews of responsiveness and service quality
- Taking into account both the user's and provider's perspective
- Strategies for responsiveness
- Option for demand generated interventions
- Monitoring service quality
- Systematic efforts to improve quality through training, BCC, evaluation and feedback
- Working on a private partnership protocol
- Convergence and converting single doctor sub-optimal PHCs to at least two doctor FRUs.

1.4.1.5 Convergence with other critical sectors

Issues:

- Need to converge with related sectors, whose actions would lead to joint outcomes
- Fragmented approach
- Duplication
- Loss of opportunities to achieve effectiveness

Strategies:

- Inter-relations between sectors have been considered
- Build in co-ordination at state levels and below
- Coordination with National AIDS Control Program (NACP)
- Coordination with Integrated Child Development Services (ICDS)

The above are strategies running across the thematic interventions for the different RCH Phase II components and these have been considered as generic strategies that need to be implemented to achieve the overall goals to attain sustainable systems over the program period.

1.4.2 Results framework

All development partners supporting the program have agreed to a common set of indicators and one integrated monitoring system for the program. The states would have the freedom to set their own levels of achievement for these indicators taking into consideration the national and state population policies, national health policies and the Millennium Development Goals (MDGs). The agreed indicators would be reflected in the memorandum of Understanding (MoU) that the state enters with the MoH&FW.

Subsequently, the states may have similar arrangements with the districts. The Results Framework with respect to each component in context to the baseline period and over the next four years is indicated below:

The Results Framework

Outcome Indicators	Desegr-egated by	Base-line 2003-4	Objectives set to be Achieved				Data Collection and Reporting		
			Yr. 1 2005	Yr. 2 2006	Yr. 3 2007	Yr. 4 2008	Frequency of Reporting	Data Tools	Responsibility for Data Collection
% of eligible couples using modern contraceptive method	Permanent Methods	34%		35%		36%	Annual	■ MIS ■ HH Surveys ■ Indep-endent Evalu-ations	■ M&E Division, MOHFW ■ International Institute for Population Sciences ■ RCH Officers of respective states
	Spacing Methods	11%		12%		16%	Annual		
% of eligible couples using any modern contraceptive method	Overall	45%		47%		52%	Annual		
	SC/ST	41%				45%	Mid term & End line		
	EAG States	33%		35%		40%	Annual		
% of deliveries conducted by skilled providers	Overall	48%		55%		60%	Annual		
	SC/ST	35%		40%		45%	Mid term & End line		
	EAG States	32%		35%		45%	Annual		
% of 12-23 months children fully Immunized	Female	44%		60%		75%	Mid term & End line		
	Male	45%		60%		75%	Mid term & End line		
	Overall	45%		60%		75%	Annual		
	SC/ST	39%		50%		75%	Mid term & End line		
	EAG States	28%		45%		60%	Annual		
% of mothers and newborns visited within 2 weeks of delivery by a trained worker	Overall	<10%		20%		40%	Annual		
Polio free status achieved		10 states have polio		Over 30 states polio free		All states polio free	Annual		National Polio Surveillance Project

* Female Methods: Tubectomy, IUD, pill and others

** Male Methods: Vasectomy, NSV and condoms

Results Indicators for each Component

Output Indicators	Baseline 2004	Objectives set to be Achieved				Data Collection and Reporting		
		Yr. 1 2005	Yr. 2 2006	Yr. 3 2007	Yr. 4 2008	Frequency of Reporting	Data Tools	Responsibility for Data Collection
Component I Number of states/ UTs successfully completing institutional mobilization phase	15	35				Annually	Annual Reports	Director, Donor Coordination, MOHFW
% of districts plans with specific activities to reach vulnerable groups	NA		25%	50%	75%	Annually	District Plans	Designated Nodal officer, MOHFW State RCH officers
% of districts reporting quarterly financial performance/ annual audit reports in time	NA	60%	80%	100%	100%	Quarterly/ Annually	FMRs Audit Reports	Financial Management Group, MOHFW State/SCOVA Financial Consultants
% of district not having at least one month stocks of critical inputs	NA	<25%	<10%	<5%	<5%	Quarterly	MIS reports	M&E Division, MoH&FW State Demographers
% of sampled outreach sessions where guidelines for AD syringe use and safe disposal is followed	NA	25%	50%	75%	>75%	Quarterly	Quality reviews	M&E Division External quality reviewers
% of 24 hr. PHCs conducting more than 10 deliveries per month	NA	10%	25%	50%	60%	Annually	MIS reports and Management reviews	M&E Division External reviews
% of upgraded FRUs offering 24 hrs. emergency obstetric care	NA	10%	25%	50%	60%	Annually	MIS reports and Management reviews	M&E Division External reviews
Number of states/ UTs contracting non-government sector improve delivery of essential RCH services	NA		15 states/ UTs			Annually	Annual reports	PPP Unit, MOHFW and State RCH Officers

Results Indicators for Each Component

Output Indicators	Base-line 2004	Objectives set to be Achieved				Data Collection and Reporting		
		Yr. 1 2005	Yr. 2 2006	Yr. 3 2007	Yr. 4 2008	Frequency of Reporting	Data Tools	Responsibility for Data Collection
Component II Institutional arrangements for NHSRC finalized	NA		Inst. Arr. Finalized			Once in 2007	Annual Reports	Donor Coordination Division, MOHFW
% of EAG and NE states visited by the MOHFW state facilitation teams	NA	50%	75%	100%	100%	Annually	Annual Report	EAG Cell and Donor Coordination Division, MOHFW
Timely completion of mid and end line surveys and studies	NA		Midline survey		End-line survey	In 2006-07 and 2009-10	Survey reports	M&E Division, MOFHW and International Institute for Population Sciences
% of districts that were able to implement M&E triangulation	NA	Pilot	15%	20%	50%	Annually	Annual Reports	M&E Division, MoH&FW and State Demographers
Mechanism for performance awards in place	NA		Mecha-nism instit-uted				Annual report of MOHFW	Donor Coordination Division, MOHFW
Component III Non-polio acute flaccid paralysis rate of at least one per 100,000 children below 15 years	AFP rate 3.4	AFP rate >1	AFP rate >1	AFP rate >1	AFP rate >1	Annually	Reports of NPSP	National Polio Surveillance Project, India
Stool Samples collected from at least 80% of acute flaccid paralysis cases within 14 days	82%	>80%	>80%	>80%	>80%	Annually	Reports of NPSP	National Polio Surveillance Project, India

Indicators Suggested for Performance Bonus

% of allocated funds for the year disbursed	<10%	10-20%	20-30%	30-40%	40-50%	50-60%	60-70%	70-80%	80-90%	>90%
Score	1	2	3	4	5	6	7	8	9	10
% contributed by SC/ ST populations among deliveries reported by public facilities compared to population in state*	% age in State +/- 5%			5-15% above % age SC/ST population in State			over 15% above % age SC/ST population in State			
Score	3			6			10			
% achievement of planned measles coverage among SC/ST population*	<10%	10-20%	20-30%	30-40%	40-50%	50-60%	60-70%	70-80%	80-90%	>90%
Score	1	2	3	4	5	6	7	8	9	10

* These indicators are to be validated every year by an independent agency

It is proposed to give equal weight for disbursements and each of the indicators for improved program performance. For both program performance indicators, the attention would be on improving coverage for SC/ST populations which has to be validated by independent agencies. These indicators would be appropriately modified to suit the needs of the states. For example, in case of NE states, monitoring changes would be correlated with BPL populations, not ST.

1.5 Other Areas of Focus

Targeting of services

- Define essential services for the poor and the vulnerable
- Review physical and financial performance against such priorities
- Resources to be used mainly to finance essential services that address the needs of the poor
- Need-based/performance-based financing

Strengthening service delivery

- Provide quality, accessible and client sensitive services
- Enabling contracting of staff, mobility support and contingency
- Support to service providers and clear mandates on supervision
- Focus on essential services and improve utilization

Infrastructure and maintenance

- The assessment of potential utilization is the key determinant for creation of infrastructure
- Complementary factors such as power, water, approach roads and communication to be strengthened through convergence and networking with other sectors
- Strategy for infrastructure developed.

Supply of drugs and equipment

- In consonance with essential drugs policy
- Estimation bases developed to assess requirements
- Logistics management strategy developed

Health care providers

- Appraisal of options of the role, scope and potential for partnership with the private sector and NGOs
- Enhance the private-public partnership mechanism through win-win situations
- These strategies outlined above would lead to the achievement of the vision in the long-term

Improved transparency and efficiency in procurement of goods and services

- Strengthening the implementation of good manufacturing practices to ensure supply of quality pharmaceuticals
- Ensuring better competition and price by undertaking periodic surveys to get more reliable information about the market
- Strengthening logistic systems to deliver quality goods and services in a timely manner to the end users
- Promoting transparency in procurement and disclosing information on procurement actions

1.6 Policies and Vision of the Government of India

Based on the identification of policy requirements and strategies the Government of India has formulated the following policy and vision matrix:

Government's Vision and Proposed Actions in RCH

Issues	Government's Long Term Vision to attain its goal and to move towards MDGs	Supported Actions and Contribution to the Long Term Vision
Planning is over centralized and requires more flexibility at the state level	To increase the ownership at the state level by encouraging the states to make their own plans by determining their priorities in accordance with the national framework. In turn, the states also need to encourage decentralized planning at the district and block levels to increase ownership.	Build capacity of the states to equip them with methodologies, improve analysis and determine their priorities, so as to enable them to draw up realistic state specific plans. To enable the states to meet a minimum level of service package. Strategies to be adopted for the different technical areas to be based on the state scenario (Differential Approach).
Fragmented approach in various activities and initiatives	Develop a coherent framework for the program	Convergence of the various RCH partners' activities/ projects to be brought about within the states.

Contd...

Issues	Government's Long Term Vision to attain its goal and to move towards MDGs	Supported Actions and Contribution to the Long Term Vision
Diffused accountability for performance	To operationalize performance linked financing through the adoption of suitable mechanisms such as the Memorandum of Understanding (MoU).	Establishing state ownership and accountability through mutually agreed performance benchmarking. Performance benchmarking through a relevant/ appropriate choice from a set menu offered and reflected in the state plan. Strengthen the monitoring and evaluation system by redesigning it to make it effectively operational in order to be able to measure outputs and outcomes.
Weak managerial and technical	Enhance the capacities at the center, state and district levels.	Improve program management capacities at the center, state and district levels with clearly defined functions.
Capacities at different levels hampering program performance	Through strengthening of structural arrangements and technical assistance	Enhance and ensure the stability of tenure of key positions through appropriate HR policies (MoU). Provide avenues for lateral infusions in the Program Management Structure through contractual arrangements, including public/private/voluntary partnerships. Structures with appropriate skills in different functions to be created at different levels. HR Policies and systems to be developed in the states to bring about specialized cadres.
Public Health System operating as a stand alone system without satisfactory integration with the private sector	Bring about a more comprehensive sector approach	Public-private partnership to begin in-service delivery and gradually scaled up to cover preventive/ promotive health. Wider stakeholder involvement in providing support for critical aspects such as behavior change communication. Contracting out service delivery to private institutions. Provision of private contractual services to ensure services round the clock. Enhanced policy dialogue and transparent/simple systems for stronger collaboration.
Perceived poor quality of services at public sector causing under-utilization	Improve quality, access, coverage, assured service availability and effectiveness.	Operationalize and strengthen infrastructure through focused investments in the delivery of the essential core package, including more integrated management of safe motherhood and child survival strategies.

Contd...

Issues	Government's Long Term Vision to attain its goal and to move towards MDGs	Supported Actions and Contribution to the Long Term Vision
		Upgrade pre and in-service training nationwide, including gender sensitivity, governance issues and provider attitudes. Demand side aspects to be included into the supply side strategies by building an effective demand supply nexus. Better and more focused BCC strategies.
Reaching underserved population including urban poor	Review of norms for defining work areas to bring about effective inter-sectoral coordination and more effective service planning	Review and develop flexible norms for coverage from sub-center upwards through multiple (common sense) criteria rather than the single criteria of population. Create alternative mechanisms for sustained coverage of the underserved and peripheral/remote areas including slums, taking into consideration natural and logistic constraints. Effective integration with the Department of Women and Child and Department for Rural Development's work through the setting up of joint planning committees and working groups, including relevant ministries.
Insufficient involvement of Panchayati Raj Institutions and Urban Local Bodies	Promotion of the role of PRIs/ULBs	Increase involvement of Panchayati Raj Institutions (PRIs) in primary health services through technical assistance and involvement in design, implementation and monitoring of RCH activities.
Sustainability of Funding	Strengthen systems of institutional and financial sustainability	Decentralized ownership from the states; donor convergence; enhancing allocation under five year plans; burden sharing with the private sector.
Need for improving transparency and efficiency in procurement to ensure supply of quality health sector goods and services in time	Improve transparency in procurement through better community oversight and strengthen procurement capacities at central and state levels	Government of India has made Good Manufacturing Practices (GMP) mandatory for the pharmaceutical industry. WHO GMP certificate will be issued only after a satisfactory joint inspection by the center, state and an independent expert. Random post GMP certification audits (covering 10% of sample) by independent experts.

Contd...

Issues	Government's Long Term Vision to attain its goal and to move towards MDGs	Supported Actions and Contribution to the Long Term Vision
		Lot sizes, estimated price and qualification criteria will be finalized based on market surveys of products, prices and capacities of manufacturers. Independent experts will be included in bid evaluation process. Procurement capacities at the center strengthened with the establishment of an Empowered Procurement Wing and an action plan to build capacities of this wing and state procurement units is being implemented. Procurement monitoring and complaints data is being established to monitor adherence to procurement manual. Periodic procurement reviews by independent experts. All procurement actions, including annual procurement schedules, bidding documents, requests for proposals, prequalification, all bids received, reasons for rejections and award of the contracts, will be disclosed at MOHFW website and this information will be made available to any member of public promptly upon request.

2

Lessons from RCH Phase I

2.1 How will RCH Phase II Improve on RCH Phase I?

Many lessons have been learned from RCH Phase I. These and the steps taken to address them are set out in the Table below. The design of RCH Phase II specifically seeks to address the lessons learnt from RCH Phase I to effectively reach the national long-term goals through flexible, cohesive and strategic planning. The approach to RCH Phase II treats a five-year funding cycle (termed project) as part of a longer-term program to achieve the long-term health and population outcome goals. Re-orientation and adjustment will be necessary and will be carried out in a progressive manner during the implementation of the first five years of RCH Phase II. Progress across the country will neither be uniform, nor linear in time.

How RCH Phase II Suggests Improvements over RCH Phase I

RCH Phase I issue	How RCH Phase II design will address this issue
1. Limited involvement of states and limited ownership by states of RCH Phase I	The design process started with a national consultation with all states. The RCH Phase II Program Implementation Plan (PIP) is designed to set out broad strategic direction, define a core minimum service package and estimate national resource requirements. Within this broad evidence-based strategic direction, states will prepare five-year plans linked to clear outcomes after assessing their own priorities, allowing a needs-based state-specific plan to be developed. States will be encouraged to form a multi-disciplinary planning team, involving local stakeholders and resources with a view to prioritizing state needs. States have been offered a wide choice of sector reforms and improvements that they may include in the MoUs, to increase accountability and establish linkages between performance benchmarking and fund flow. States will themselves plan and select their outcome and process indicators and reform areas or improvements to achieve the indicators.

Contd...

RCH Phase I issue	How RCH Phase II design will address this issue
2. Pace of implementation to be made faster	The core service package is defined and will be included in all state's plans for implementation. The MoU will be used as a performance benchmarking/mutual monitoring mechanism and also ensure accountability. Bottlenecks to fund flows will be removed by simplifying processes.
3. Enhancing utilization of public health facilities	This has been diagnosed as being due to users' perceptions of low quality, frequent service unavailability and low acceptability of some services. This will be addressed through pre-service and in-service training, with a particular focus on provider attitudes and making services more user friendly. Contracted staff will be engaged and their performance monitored to ensure continued availability of services. The core services will include quality standards. Demand side stimulation activities will be an important part of state plans. BCC activities will be focused on improving the image of public health facilities, promoting new services and improving health- seeking behavior. Facility norms will be reviewed and altered using multiple criteria to effectively match need of users.
4. Infrastructure to be completed within the project time frame	The core service package will ensure the availability of essential infrastructure. Outsourcing will be undertaken with agreed institutional mechanisms to manage infrastructure and to ensure accountability and delivery of reliable and quality services. The processes of managing and construction of infrastructure will be simplified.
5. Limited management capacity	There will be a lateral infusion of skilled personnel to improve the management capacity structure at the national, state and district levels, with clearly defined functional responsibilities and roles. A system will be established to ensure continuity in the tenure of key posts and positions. States will review the roles of different cadres and restructure them to strengthen public health and user needs orientation of services as a part of the MoU.
6. Need to incorporate the system of smooth flow of funds	A study of financial management had been undertaken to identify and understand the bottlenecks in the current system and design mechanisms to remove them and simplify the flow of funds. The recommendations of the study, after suitable validation, have been examined for improved financial management. The MoUs will clearly define the central government's responsibilities regarding the flow of funds and the state governments' responsibilities on performance and associated expenditure. Accounting procedures for reporting and the process of review will be simplified through an accounting and financial manual, which has been prepared by the center. Financial management systems will be built into the program management structure. Professionals/chartered accountants are being inducted in the area of financial management.
7. Need to have a vision and policy guidelines in RCH	A clear vision statement has been developed (section 1.1). A strategic plan has been agreed upon and a strategic direction is laid out in the short, medium and long term (section 1.4).

Contd...

RCH Phase I issue	How RCH Phase II design will address this issue
	Strategic objectives and policy options are well articulated (section 1.3). Outcome indicators have been identified from various policy documents and commitments at international summits (section 1.2).
8. RCH Phase I was implemented as a project; there was a need to incorporate well-defined outcome indicators	RCH is visualized as a long-term program, oriented towards achieving ambitious, but realistic health outcomes and improvements in CPR and TFR. The 5-year period is looked upon as a 'project' within this larger time frame, but with definitive outcomes moving towards the long-term goals. The national level program framework is the overview, whilst state level planning will be oriented towards a more limited timescale (5 years) and linked to specific health outcomes relevant to the state that will cumulatively lead towards achieving the goals of national health outcomes. State PIPs will be refined on an ongoing basis as the experience of implementation and results from studies feed in to the state planning process, recognizing that state capacity varies widely.The planning and design will be a dynamic process and the national and state PIPs, Log Frames and MoUs will be live documents.
9. RCH Phase I had a "one size fits all" design	States will have different requirements, levels of performance and capacities and will be able to take these into account when designing their state PIPs. Such a differential approach may be extended to the district level depending upon the performance of districts. The BCC, though centrally designed, will also be state-specific. The state PIPs will ensure the equitable availability of quality RCH services, which have been designed taking into account the needs of local communities and state capacities. Equity issues especially towards the poor and vulnerable will be addressed through the M&E system and community monitoring.
10. Need to move away from "stand alone" public health approach	RCH Phase II will adopt a program approach, bringing in key elements of sector management and reform and strengthening of systems. Partnerships will be built with PRIs, ULBs, the private sector, the NACP and the ICDS program during the RCH Phase II.
11. RCH Phase I focused almost exclusively on the supply side	Whilst RCH Phase II necessarily includes supply side strategies, these will be complemented by an integrated and robust strategy to stimulate demand for services. One part of the demand side strategy will be a comprehensive and coordinated BCC plan, which specifically addresses issues such as the perceived low quality of services, the availability of services and promoting health-seeking behavior. A study specially commissioned on the demand supply nexus has been taken into account in the design. The family planning initiatives will also be integrated in RCH.
12. RCH Phase I was centrally designed with little consultation	RCH Phase II has been designed after wider consultation. EAG states will be assisted in formulating their PIPs. MoH&FW accepts that the national PIP is an operational framework.

2.2. Examples of Reforms and Innovations Relevant to RCH Phase II

2.2.1 Improving drug procurement and supply systems

To tackle the problem of irregular, inadequate and inappropriate drug supplies at both the primary and secondary care levels, the state of Tamil Nadu set up a streamlined system, which permits central procurement of all the drugs on the state's Essential Drugs List. An efficient distribution system has been put in place with district drug warehouses for the decentralized distribution of drugs, and a simplified indenting system, which facilitates the ordering process for health service facilities. A full quality control system has been implemented and a computerized information system allows continuous monitoring of warehouse inventories.

Implementation: Such a scheme could be implemented in non-EAG states with DP support for the capital expenditure involved (notably the construction of district level pharmaceutical warehouses).

2.2.2 Introducing maternal and infant death audits

There has been systematic reporting and auditing of maternal deaths in Tamil Nadu for several years. All maternal deaths are reported directly to the Deputy Director of Health Services or the Deputy Director of Medical and Rural Health Services as appropriate, within 24 hours. A clear system has been developed, which specifies the person responsible for reporting the death according to whether it occurred at home, in transit, in a primary health care facility, a public hospital or in a private facility. The Commissioner for Health & Family Welfare is informed within 24 hours. District level maternal death teams (accompanied by the local PHC medical and nursing staff) investigate and are expected to submit their report within 15 days of the occurrence of death. The investigation is treated as a case study and not as a faultfinding exercise. There is rapid feed back of Information to enable health workers to learn and take remedial action. This system is now being used in several states for both maternal and infant deaths.

Implementation: The systematic audit of maternal and infant deaths should be introduced throughout all non-EAG states. This can be perceived as threatening if not managed carefully, and the first step is often to establish facility "success" audits, then "near miss" audits before full maternal death audits are done. Maternal death audits should be introduced as a pilot scheme with DP support in several districts within each of the EAG states.

2.2.3 Monitoring of institutional activity at primary health care level

A simple-to-use, manually completed, computer-readable data collection and monitoring form which gives details of outpatient and inpatient attendances, contraceptive services, number of deliveries, sterilizations, minor operations, laboratory investigations, vaccines, and ambulance and PHC vehicle use may be introduced. The collected forms will be analyzed and the information fed back by the Public Health Directorate of the State Department of Health and Family Welfare. Where it has been introduced, monitoring has had a sharp impact on PHC performance with outpatient attendance increasing by one third, while the number of PHCs performing deliveries has doubled.

Implementation: Systematic recording of activity information could be introduced in all non-EAG states. The system could be introduced as a pilot scheme with support in several districts within each of the EAG states.

2.2.4 Flexibility: District PIPs based on community needs assessment

A flexible approach to the District Action Plan system based on community needs assessment principles has an impact. District Action Planning that addresses community needs is more effective. There have been successes such as the *Vikalp* project in Rajasthan, which helped orient services towards community needs and assisted PHC level activities such as MCH and IEC. Such decentralized planning and setting realistic targets in an incremental manner is more effective in states where no targets were set earlier.

Implementation: Each state should design its decentralized planning mechanism under the guidelines issued by the central government. In the beginning the EAG states may require, in particular, technical and managerial support to implement such an exercise.

2.2.5 Ensuring block and district level inter-sectoral coordination for ICDS

Inter-sectoral coordination can be brought about at the block and district level when facilitated by an NGO or a DP, as illustrated in the ICDS project. Coordination focused on a specific goal at the block or district level (e.g. coordinating various departments for pulse polio campaign or family life skill training at the secondary school level).

Implementation: Inter-sectoral co-ordination should be ensured at the block and district levels through block-and district-level advisory committees involving ICDS, RCH, Departments of Primary Education, PWD, Rural Development, Forest, Police, Women and Child Development and Tribal Development. An NGO can facilitate the process. Common goals like better nutrition for children and lactating mothers and institutional deliveries of pregnant women can be addressed.

2.2.6 Practices that appear promising for PIPs

Six further areas of promising strategic importance have been identified that should be followed up in order to clearly identify good practices and assess their suitability for implementation.

2.2.6.1 Social marketing

There is an urgent need for reorientation of the existing social marketing policy framework to reach underserved populations, widen the basket of services available and step up social franchising, which could help to improve both the quantity and the quality of services on offer. Draft legislation has been under consideration for some time now and the launching of the RCH Phase II would appear to be a good opportunity for re-launching this initiative, since this would enable the implementation of a series of good practices. The review should include a full analysis of the more promising programs (e.g. Green Star in Pakistan, SIFPSA).

2.2.6.2 Regulation of private hospitals

Although it varies between regions and states, more than two thirds of health care activity in India takes place in the private sector, which is currently expanding more rapidly than the government sector. Though the economic weight of this sub-sector and the part of household budgets devoted to private health care are substantial, it remains largely unregulated. There are now, both in India (Karnataka and Mumbai) and elsewhere, a number of emerging “promising practices” in relation to the registration of private hospitals and nursing homes, which merits study to help fill this regulatory gap.

2.2.6.3 Transport for obstetric emergencies

Examples exist in India (current West Bengal ambulance pilot scheme) and other countries, notably Sri Lanka, of systems for subsidizing emergency transport or alternatively, for the organization of emergency transport at the local level through community action. The transport problem has been approached from another angle in several countries, notably in Cuba and Egypt, by making available maternity waiting homes. It has been demonstrated that this can have a significant impact on maternal mortality statistics and this topic should therefore be investigated in more detail.

2.2.6.4 Community volunteers

There are many interesting examples throughout the country (notably in Kolkata), of neighborhood volunteers being trained as voluntary link workers or peer group counselors. The activities undertaken by the link workers vary from BCC and advocacy, through to distribution of contraceptives and iron tablets. Systems for remuneration vary too; from completely voluntary activity through symbolic personal remuneration or subsidies to local women's groups, to remuneration on the basis of the number of products sold or distributed. This may be an effective way of establishing contact with difficult-to-reach groups, and although a certain number of evaluations of individual programs have been carried out, there has until now been no systematic review of the whole range of projects aimed at extracting collective lessons.

2.2.6.5 Role of the primary care center medical officer

The lynchpin of the Primary Health Center and probably the most critical factor with regard to its smooth functioning and effectiveness is its Medical Officer. However, different individuals interpret the role in very different ways and there is no universally recognized role model. It would be useful to study the role of the Medical Officer in both successful and less successful PHCs to determine the critical factors in terms of their effectiveness.

2.2.6.6 Inter-sectoral co-ordination in the field

The relationship between the anganwadi worker and the ANM at the village level and their respective working methods, is critical to the improvement of child health services in rural areas. Different permutations exist and this range of options should be explored under the RCH Phase II to capture and institutionalize the good practices that have been developed.

2.2.6.7 Activating primary health care services

Those states where PHCs and sub-centers generally function well often follow a range of measures being introduced simultaneously. It seems to be important to act on several fronts at the same time, in order to create a high degree of synergy. More specifically, the following set of interventions taken as a whole appears to give impetus and dynamism to the improvement of operating PHCs.

- Community ownership of health issues including investment in premises and support for the ANM.
- Community commitment to obstetric emergency transport or the existence of maternity homes adjacent to 24-hour staffed delivery facilities.
- Positive encouragement by the DoH&FW to facilitate the mobility of ANMs (loans for two wheelers, training, and assistance with licensing procedures).

- Proper referral systems to ensure skilled attendance at deliveries.
- Introduction of 24-hour staffing schemes in PHCs.
- Adequate training of ANMs in emergency obstetric care.
- Implementation of a facilities monitoring system (MIS).
- Training of TBAs in five days and orientating them towards newborn care.
- BCC aimed at educating families in caring for pregnant women and newborns.

3

Institutional Arrangements

3.1 National Level Implementation Organization

In contrast to the RCH Phase I Project, RCH Phase II is a program that seeks to include key elements of sector wide management (structure, processes and financial flexibility) within its design so as to maximize the chances of program success and significant sector reforms. The lessons of RCH Phase I have been specifically addressed in the design of RCH Phase II, leading to more emphasis on state-specific planning, targeting the vulnerable, demand side stimulation, strengthening systems, health and population outcomes and flexible financing.

At the national level, in consultation with the states, a broad strategic program design articulated in the National Program Implementation Plan, has been set out for the RCH Phase II. Guided by this, states will undertake their own program planning to produce state PIPs.

Estimating resources, coordinating donors and the generation of resources will be carried out at the national level with the support of skilled and professional staff. It will function under the overall supervision of the Secretary, MoH&FW and will have an Additional Secretary/ Joint Secretary in overall charge of the program. It may include existing staff or contract staff. This structure will have different functions within the RCH Phase II program as outlined below.

3.1.1 National level functions

Exercises are already being carried out at the central level to assess reorganization requirements, which will provide greater details of the type of structure and functional arrangements that need to be put in place. Further, a study conducted on financial systems has been explored to outline the type of structures that will be required to handle the finance function. The logistics management and procurement divisions envisaged by the Government of India will provide key inputs for defining structural arrangements at the national level for procurement and logistics. The immunization division envisaged by the center will attempt to streamline the immunization activities of the center and the states. Further, it is planned that the department with its existing staff be reorganized to achieve the desired composition as far as the technical functions and the state coordinating functions are concerned. The monitoring and evaluation

function can also be carved out of the existing structure. Some positions may have to be filled through contractual arrangements and lateral infusions. This organizational restructuring is being and will be reflected gradually in the PIP, which, as has been indicated earlier, will be a live and dynamic document to take account of all the developments that take place in the due course of the RCH Phase II.

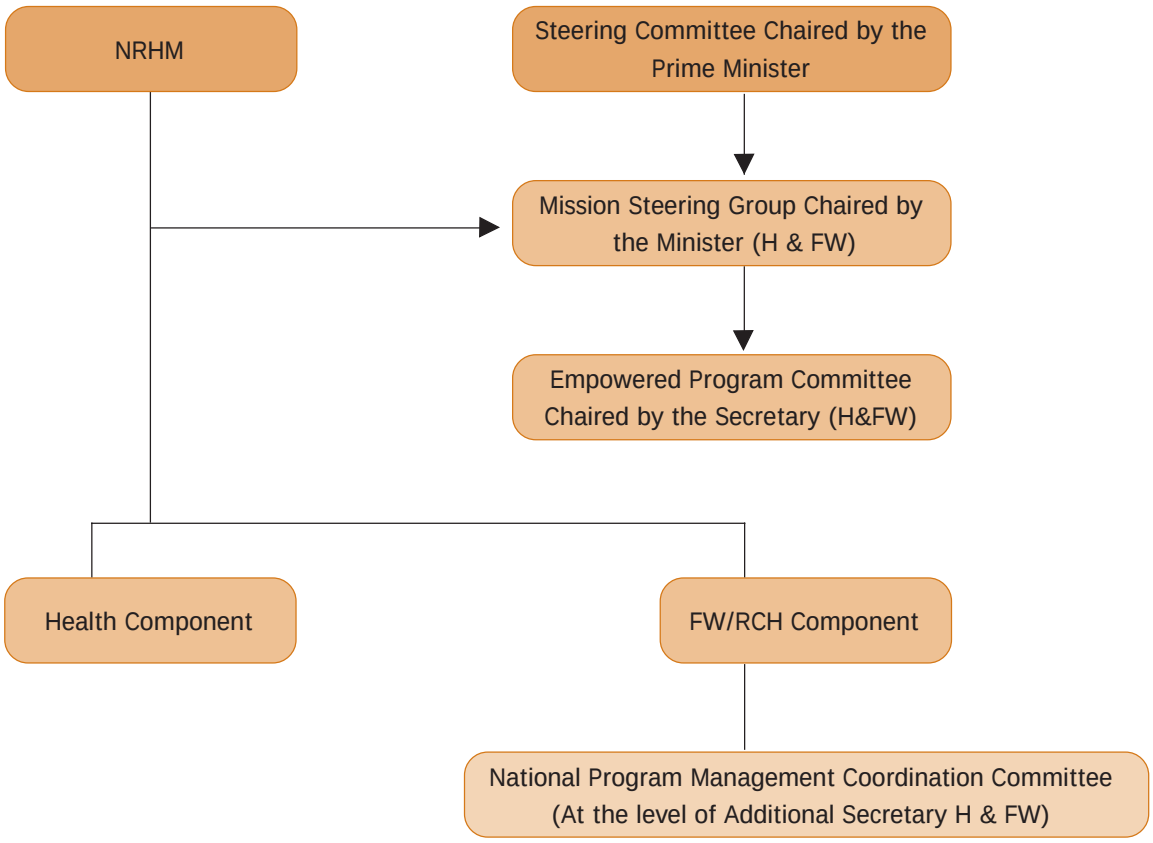
3.1.1.1 Organizational structure

The principles underlying the reorganization at the national level are as follows:

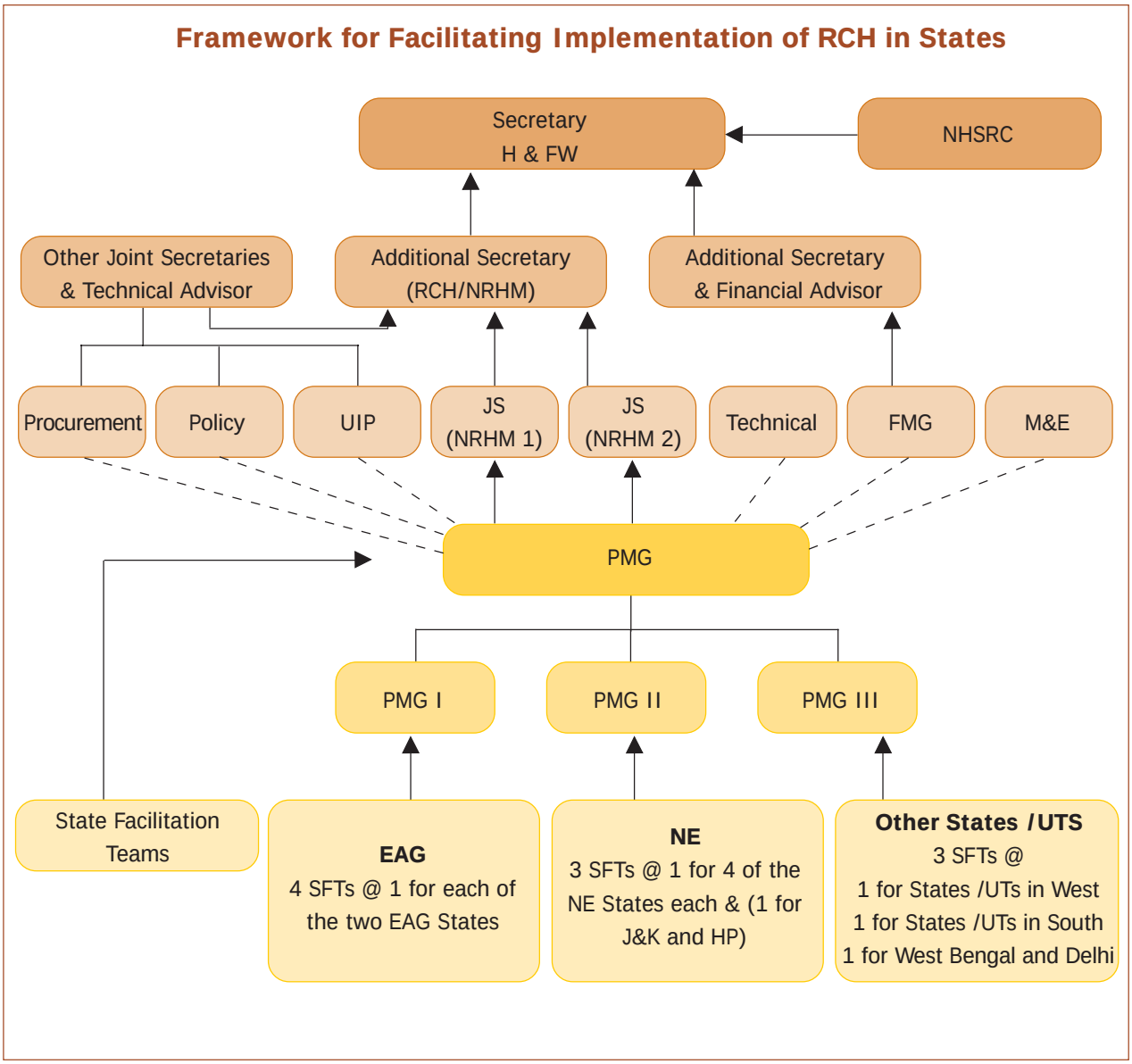
- The Steering Committee chaired by the Prime Minister, the Mission Steering Group chaired by the Minister (H&FW) and the Empowered Program Committee chaired by the Secretary (H&FW), have all been sanctioned by the cabinet.
- Orders have been issued creating the National Program Management Coordination Committee.
- The Cabinet has also agreed to the proposal of posting an Additional Secretary and four Joint Secretaries. Two Joint Secretaries are already in position in the Department of Family Welfare.
- Special attention is being given to the creation of a procurement division and an immunization division, given their critical importance in the system.
- The senior most of the heads of technical divisions is designated as a Technical Advisor to the Department of Family Welfare (DoH&FW) and remains responsible for coordinating the work of all the technical divisions.
- The Finance Management Group (FMG) is responsible for the entire financial management activities in the RCH Program. The FMG will also report to the Additional Secretary (AS) and Financial Advisor (FA) in the MoH&FW. The budget functions will also rest with the FMG
- The Program Management Group (PMG) remains responsible for all interactions with a cluster of states, so that the states need to interact with just one nodal official in the MoH&FW
- The state facilitation units will comprise a management expert (either a deputy secretary or a management consultant), an M&E officer (drawn from the statistics division) and a technical officer (of the level of Assistant Commissioner drawn from the technical divisions). This group would remain responsible for field level interactions especially with the Empowered Action Group (EAG) and National Rural Health Mission (NRHM) special focus states.
- The state facilitation officers will be responsible for interacting with the administration, the technical divisions and the M&E division as and when required.
- There will be a National Health Systems Resource Center (NHSRC) to serve as an apex body for technical assistance, dissemination and for functioning as a center of excellence for facilitating the center and the states in the program.
- The Appraisal Committee would adopt a working methodology similar to an Expenditure Finance Committee for recommending sanction of resource allocation to the state plans. The presence of an Internal Finance Department (IFD) has hence been articulated in the same.
- The National Program Implementation Committee (NPCC) will remain responsible for according sanctions to the release of resources.

- Issues that require further clearance will be resolved at the level of the Empowered Committee that comprises of Secretaries of related departments.
- The organizational chart of the Department of Family Welfare suggesting restructuring of the Department in order to be able to carry on the paradigm changes in RCH Phase II is given below.

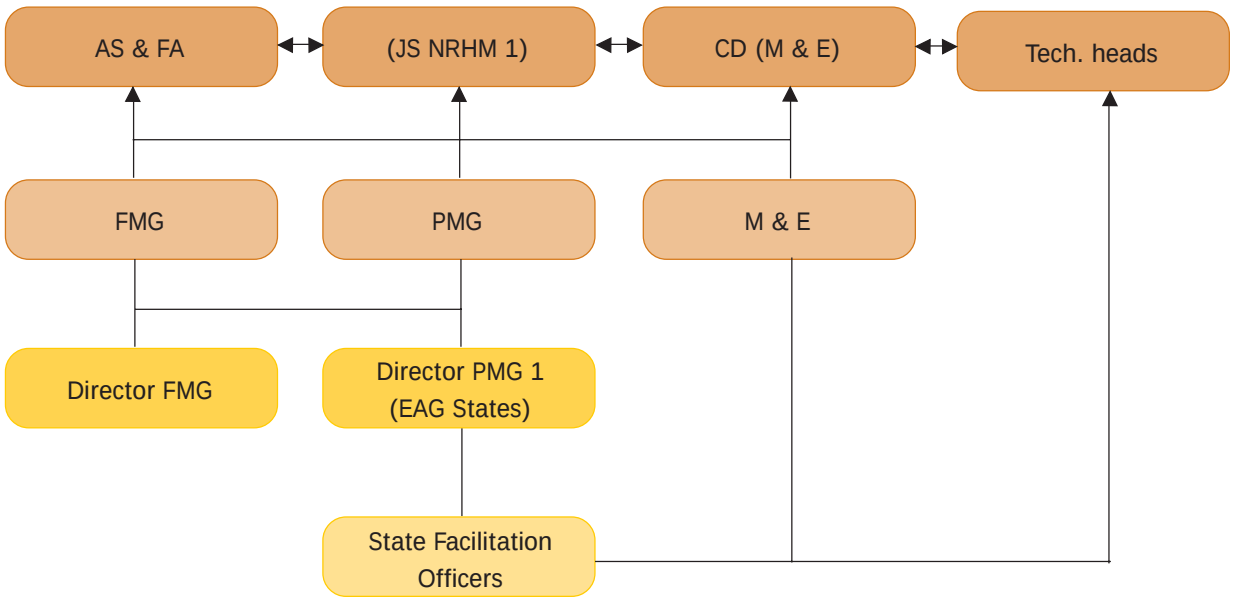
Organizational Chart for Implementation of RCH Phase II at the National Level



Framework for Facilitating Implementation of RCH in States

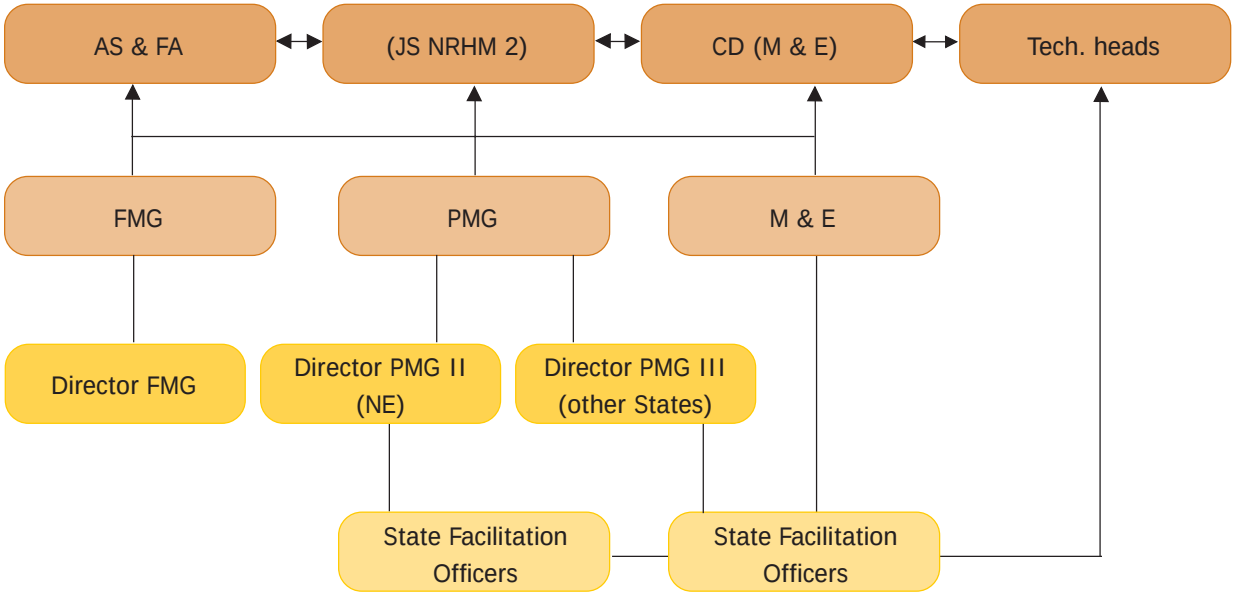


Organizational Structure for Facilitating the EAG States



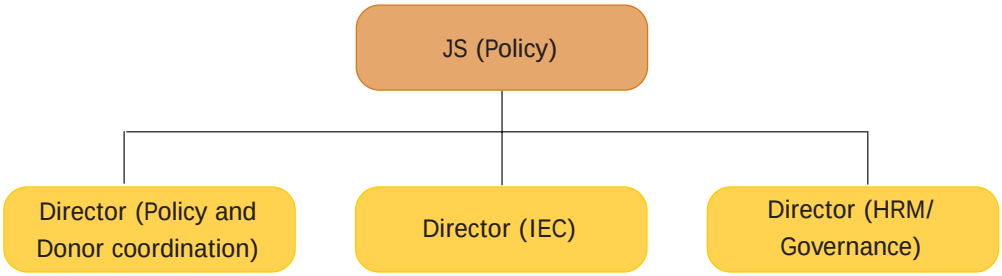
Each of the above will have a supporting Program Officer of the level of a Director assisted by Under Secretaries / Desk Officers. In so far as PMG is concerned, each Program Officer will be responsible for a cluster of states.

Organizational Structure for the Non-EAG States



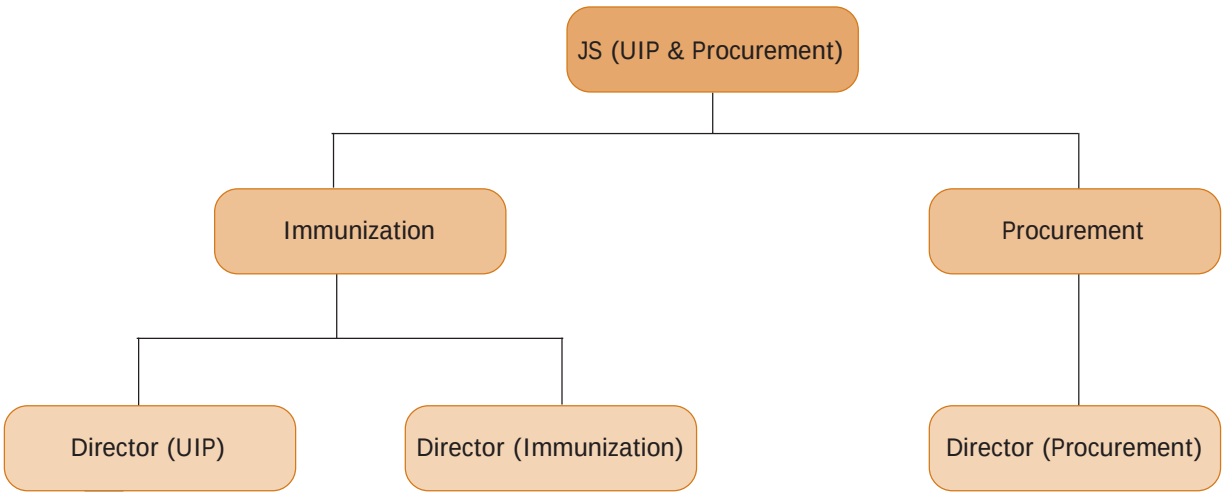
Each of the above will have a supporting Program Officer of the level of a Director assisted by Under Secretaries / Desk Officers. In so far as PMG is concerned, each Program Officer will be responsible for a cluster of states.

The Policy Group



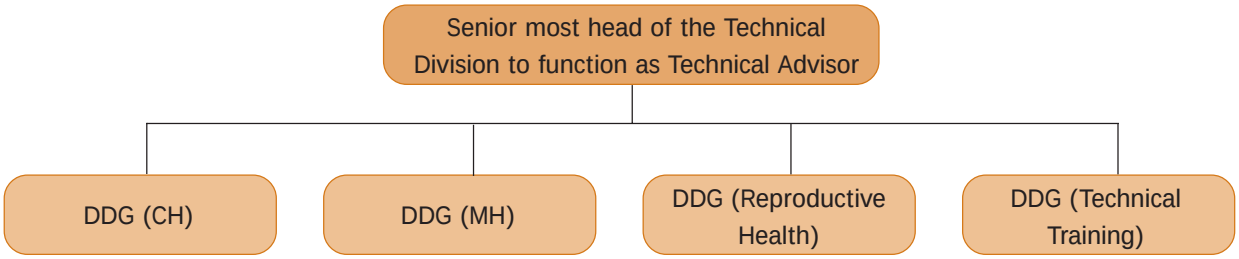
1. The Policy Division will be responsible for implementation of only those program components, which entail provision of service or procurement of goods on behalf of the states/UTs. All schemes involving direct cash transfers to states/ UTs either through the Treasury or SCOVA modes would need to be reflected in the state PIPs and dealt with by the PMGs.
2. The Director (Policy and Donor Coordination) will look after all policy issues including those relating to developing a policy framework for PPP and NGO partnerships, urban health and tribal health, issues relating to the health of other vulnerable groups, the environment management plan etc. As Director Donor Coordination, the officer will be the nodal person for all donor related policy level issues. This official will coordinate all implementation issues with the PMG, FMG and Donors.
3. The Director (HRM) will be responsible for developing a comprehensive human resource management program for the sector as a whole including recruitment, training, placement, career development, succession planning, performance enhancement and other related issues excluding technical training, which will lie with in the domain of DC (Training).
4. The Director (HRM) in essence will fill the gap on management/executive development related issues. The Director (Governance) will be responsible for the existing functions of Director (Administration). In addition the incumbent will be required to proactively examine organizational development issues including restructuring proposals at the center/ state / international levels, evolve and commission and implement e-governance strategies and focus on improving management of services at the sub-centers.

Immunization and Procurement Divisions



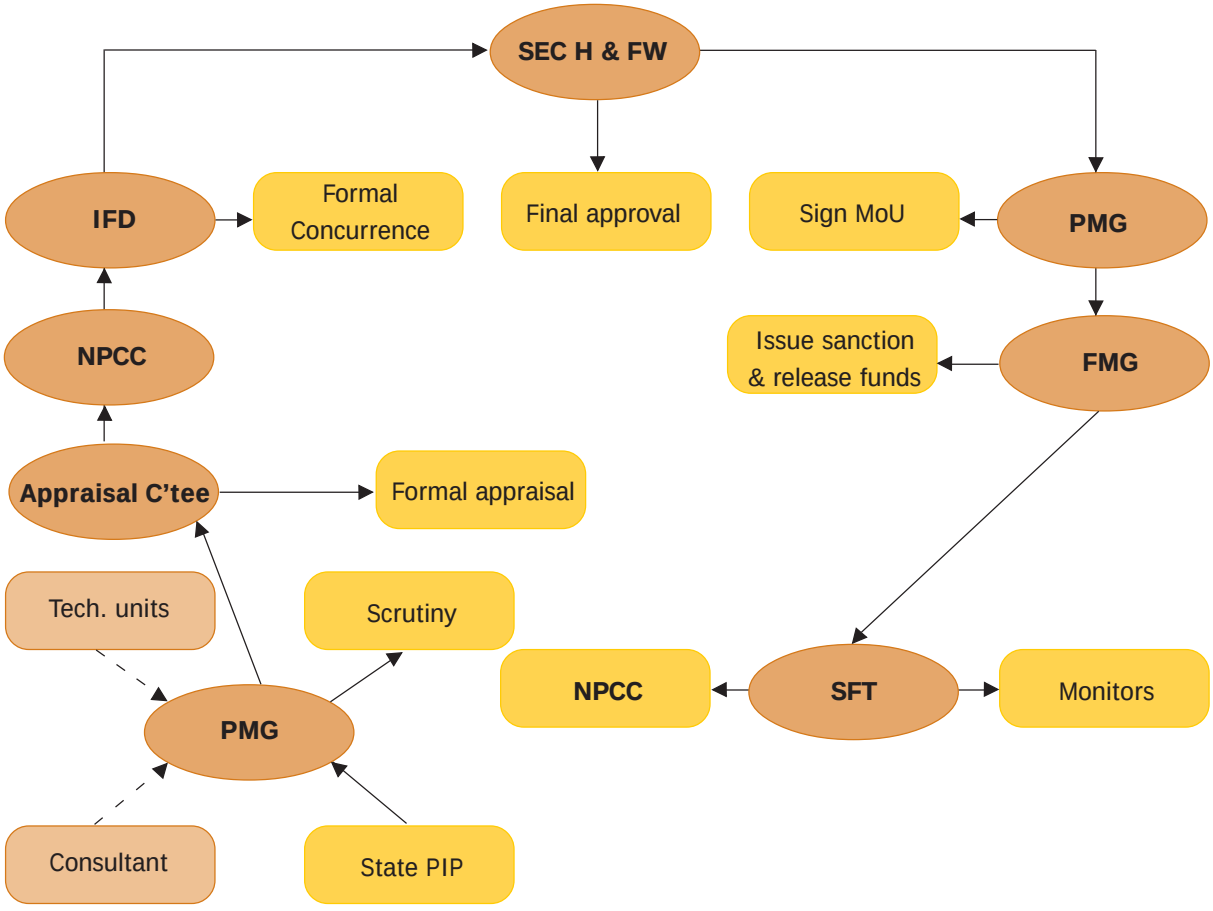
Each of the above will have a supporting Program Officer of the level of Under Secretaries/ Desk Officers.

Technical Divisions

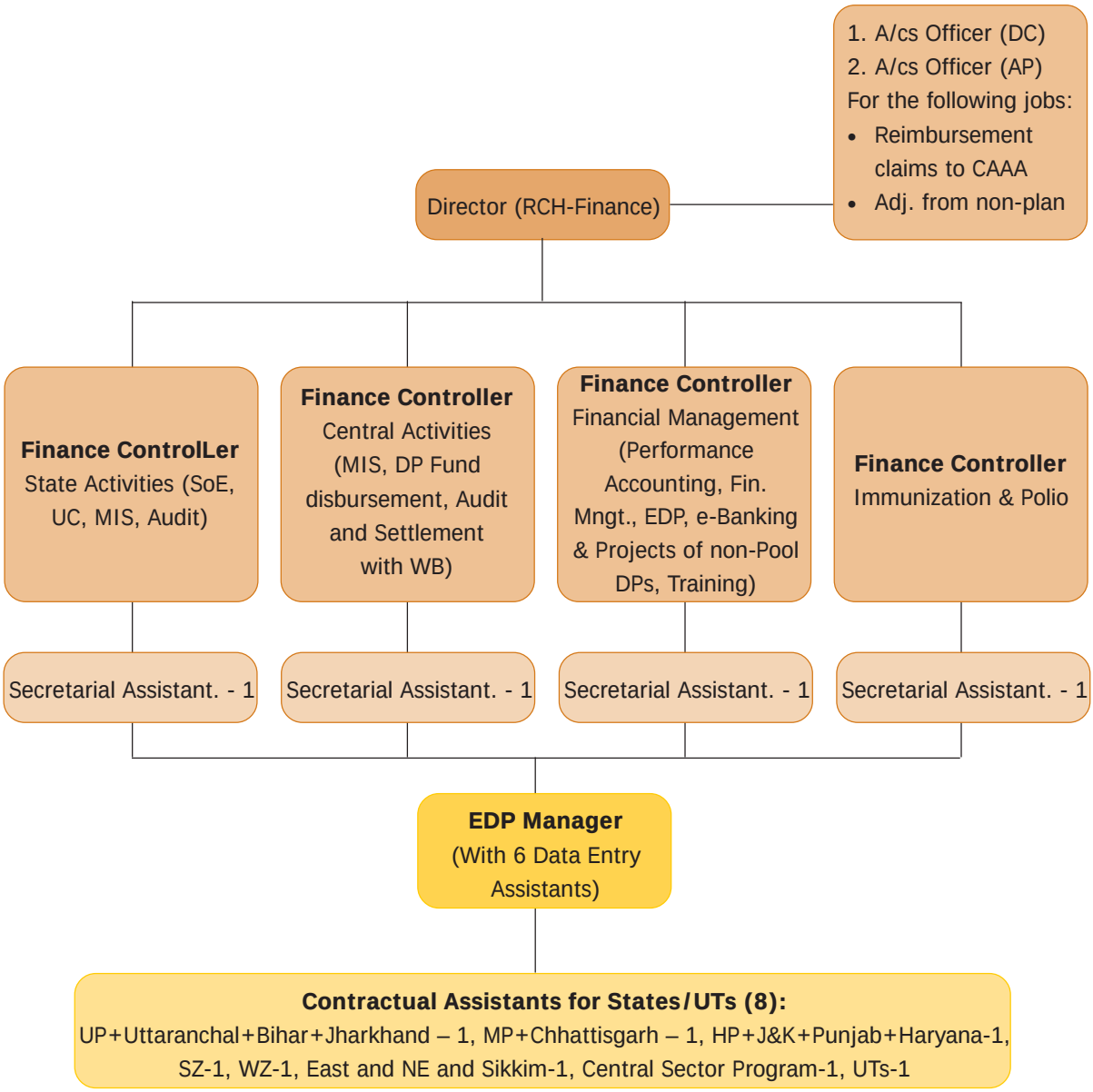


The Technical Advisor will report to the Additional Secretary (Health & Family Welfare). The technical heads will be responsible for developing new interventions, evaluating and monitoring ongoing ones, developing service protocols and standards as well as monitoring them and providing technical advice on all program management issues etc.

The Appraisal Process



The Finance Management Group (FMG)



3.1.1.2 Central policy function (role of the Policy Group)

The Policy group would comprise officials of the rank of director at the national level, who would be responsible for formulating policy guidelines and policy statements on behalf of the Health and Family Welfare department of the Government of India. This group would be headed by a Joint Secretary who would be assisted by one Director (Policy and Donor Coordination), one Director for IEC activities at the national level as well as for developing strategies at the state levels, in consultation with the states; and one Director responsible for governance and administration including e-governance at the national level and for guiding the states on the same. The structure is shown on page 34 of this document.

The terms of reference for this group would broadly be as follows.

- Develop the program in line with GoI policy (Tenth Plan document, National Population Policy and the National Health Policy)
- Formulate policy
- Assist states, with the assistance of the NHSRC, to prepare their PIPs (NRHM special focus states) thereby providing states with an evidence-based technical framework and framework for participatory planning to ensure ownership and equity of coverage
- Facilitate meeting the states' requirements for technical, managerial or resource support (financial and management) in consultation with the NHSRC
- Develop and disseminate to the states a planning cycle and calendar so as to ensure uninterrupted fund flow
- Stimulate inter-sectoral coordination among the other departments, which are carrying out relevant programs and coordinate the different wings within the MoH&FW.

The Policy Group would also be responsible for the following:

The social development and vulnerable group functions

- Identify vulnerable groups
- Design plans for such groups
- Monitor the program so as to ensure that vulnerable groups receive the benefits of the program
- Monitor data, based on collection on an disaggregated manner
- Provide overall supervision on gender, equity and access issues.

The e-governance functions

- Identification of the e-governance requirements of the sector
- Formulation of an e-governance policy
- Development of an e-governance plan
- Implementation of the e-governance strategy and plan
- Skill development and training on e-governance
- Development of governance systems and processes compatible with e-governance
- Interface with states/autonomous bodies/institutions under the Ministry and e-governance related issues
- Represent the Ministry on all external forums on e-governance.

3.1.1.3 Central program management functions (role of the Program Management Unit (PMG)

(An officer at the level of a Director will head the program management group and he / she will be assisted by under-secretaries/ desk officers and other support staff. Director PMG I will be responsible for the states known as the eight EAG states namely: Uttar Pradesh, Uttaranchal, Bihar, Rajasthan, Madhya Pradesh, Orissa, Chattisgarh and Jharkhand. The Director PMG II will be responsible for the eight North Eastern states, namely: Assam, Manipur, Mizoram, Meghalaya, Sikkim, Nagaland, Tripura and Arunachal Pradesh. The Director PMG III will be responsible for the rest of the states and Union territories in the country. The structures are given on page 33 of this document)

The terms of references of the program management group would be as follows.

- Assist states in preparing their PIPs (NRHM special focus states) providing states with an evidence-based technical framework and a framework for participative planning, to ensure ownership and equity of coverage
- Appraise the state PIPs against agreed criteria and project the resource requirements (infrastructure, human resources, logistics, drugs, consumables, equipment, training and capacity building)
- Consolidate state PIPs and produce an overall resource estimation for the program and review resource requirement projections annually
- Manage, in consultation with the FMG, both financial and other resources
- Finalize state plans and MoUs and agree to various performance indicators and milestones
- Ensure that state PIPs are balanced and congruent with the national plan and the local requirements
- Ensure, in consultation with the FMG, the timely release of resources to the states as per agreed plan
- Divide the state PIPs into core components (common to all states) and the state specific components
- Examine state performance reports against MoU milestones and correlate fund release against performance. This will include, in consultation with the M&E unit, a qualitative analysis of state monitoring processes.

3.1.1.4 Central state facilitation functions [Role of the State Facilitation Units (SFT)

(It is proposed that the SFT consists of one technical officer, one management official and one officer from the M&E unit; it is suggested that the following SFTs will be formed:

Four SFTs @ one for each of the two EAG states

Two SFTs @ one for four of the North East states

One SFT for J&K and Himachal Pradesh

One SFT for the states and union territories in the West

One SFT for the states and union territories in the South

One SFT for West Bengal and Delhi

Hence, there would be a total of 10 SFTs to facilitate the monitoring in the entire country. This unit is shown on pages 33 and 35 of this document.)

The terms of reference of the state facilitation unit would be as follows.

- Monitor the progress of the states belonging to the cluster under the respective facilitation unit.
- Examine performance reports of states against milestones as indicated in the MoU and correlate release of funds against performance. This will include a qualitative analysis of the states' monitoring processes.
- In the event of unsatisfactory performance, facilitate the individual states in understanding their problems and jointly identify solutions.
- Interact with the technical groups for providing guidelines and give clarifications to the states on the implementation of the service delivery activities.
- Interact with the M&E group to review the states' performance and also facilitate monitoring at state levels.
- Interact with the FMG to ensure efficient release of funds in states and to facilitate effective financial monitoring in the states, so as to deliver utilization certificates and SoEs on time.
- Interact with the PMG for overall coordination with the states.
- Provide technical inputs to the states in consultation with the technical group.
- Review the performance of the states from the technical standpoint and provide suggestions for improvements.
- Provide technical inputs to training modules, so as to effectively incorporate the technical strategies in training.

3.1.1.5 Central technical functions (role of the Technical Divisions);

The structure is given on page 35 of this document

- Ensure that the national plan is based on evidence and international best practices
- Ensure state PIPs are balanced and congruent with the national plan and the local requirements
- Document successful practices adopted by different states and disseminate it to other states and bring states with similar problems together
- Review the performance of the state PIPs and suggest modifications to the states where necessary, to ensure effectiveness
- Examine the alternative strategies and enable the states to choose the most cost-effective strategy
- Provide technical inputs to the states as requested by state facilitation officers
- Review the performance of the states from the technical standpoint and provide suggestions for improvements
- Provide technical inputs to training modules to effectively incorporate the technical strategies in the training.

Central finance function (Role of the FMG)

The structure is given on page 36 of this document

- Finance professionals in place
- Procure resources as per the annual plan outlay

- Prepare an accounting and financial manual
- Disburse financial resources to the states after recommendation by the state facilitator on the basis of their plan and the receipt of accounts for the period under question
- Build the states financial management and accounting capacity
- Design financial management systems to facilitate the states' accounting
- Oversee periodic skill enhancement processes like workshops, training etc., for the finance and accounts personnel at both the state and central levels
- Monitor submission of SoEs/Financial Reports from states/UTs
- Review state financial records and systems to ensure effectiveness
- Facilitate the state technical heads in appreciating the importance of financial systems to ensure the timely and smooth flow of funds and correlate progress reports with accounting and financial statements
- Negotiate with donors to ensure convergence
- Oversee the audit arrangements of SCOVAs

3.1.1.6 Central training function (role of the Training Division and the NIHFW)

- Monitor and coordinate state training needs assessments
- Develop an outline of a national training strategy and plan
- Facilitate states in developing their training strategies and plans
- Facilitate the development of training curricula, modules and guides
- Assist states in developing a system to monitor the quality of training
- Build and maintain a database of consultants, trainers and researchers (both individuals and institutions) in different fields
- Suggest consultants and trainers when requested by the states; obtain feedback from the users on the performance of the consultants/trainers and maintain it on the database
- Facilitate national and state research to inform the future development of the program

3.1.1.7 Central procurement and logistics function (role of the Procurement Division)

- Assess overall program procurement requirement
- Review current logistics and infrastructure management systems in states and the improvements necessary and assist in the standardization of successful practices followed in states such as Tamil Nadu and Orissa
- Assist states to develop transparent procurement procedures
- Enable the development and implementation of logistics and procurement management systems
- Assist states to establish systems for maintenance of equipment
- Carry out procurement through centralized agencies

3.1.1.8 Central construction and maintenance management function (role of the Infrastructure Division)

Standardize new facilities' designs e.g., sub-centers (particularly in EAG states) PHC and CHC improvements, and new warehouses.

- Review state costing, using a menu rather than a unit approach
- Assist states to develop maintenance systems (possibly outsourcing).

3.1.1.9 Central monitoring information and evaluation function (role of the M&E Division)

- Identify indicators required to monitor the performance of the program
- Identify data sources for the indicators
- Build state capacity to monitor performance and use the data to plan
- Develop and introduce quality assurance systems and monitor the quality parameters to be achieved
- Identify evaluation stages in the program
- Identify agencies, which can carry out evaluations
- Involve states in evaluation and finalizing parameters and methodology
- Arrange for dissemination of the evaluation findings to the state and assist in state planning on the basis of these findings
- Facilitate joint monitoring based on the MoU and the log frame
- Triangulation of data monitoring
- Identify areas requiring surveys or studies at the national and state levels
- Create a database of institutions, research organizations and resource persons to conduct studies and surveys
- Draft the terms of reference for studies and surveys
- Disseminate successful methodologies to states
- Interact intensively with states on the use of data for planning and monitoring

3.1.1.10 Role of the M&E Division

- Identify areas requiring surveys or studies at the national and state levels
- Create a database of institutions, research organizations and resource persons to conduct studies and surveys
- Draft the terms of reference for studies and surveys
- Disseminate successful methodologies to the states
- Interact intensively with the states on the use of the data for planning and monitoring.

3.1.1.11 Role of the Central Immunization Division

The role of the Central Immunization Division is provided at page 144 of Document 2 of the NPIP.

3.2 State Level Implementation Organization

The states will develop their PIPs in response to local needs, whilst remaining balanced and congruent with the national PIP. State level implementation structures will develop the PIPs in consultation with the districts. States will estimate the resource requirements for their PIP and finalize it with the MoH&FW, agreeing to a MoU and putting in place appropriate systems to ensure efficient implementation and monitoring of performance. Human resource planning to meet the requirements for program implementation would also be a requisite function of the state level implementation body.

The EAG states will have a particular focus on augmenting management capacity. Capacity building requirements will be assessed through a capacity building needs assessment, undertaken by the MoH&FW. EAG states have been provided with management and finance professionals (four at the state level comprising a management expert, one chartered accountant, one cost accountant and one data officer) duly facilitated by the MoH&FW. Performance linked incentives have been built into the system at the district level. The design of the monitoring system has also taken into account the quality aspects of performance. The states have to conduct triangulation exercises for monitoring and evaluation, which involves a process of generating relevant information about any indicator from mutually independent sources, both qualitative and quantitative that will minimize the potential for misreporting.

At the state level, the Principal Secretary (Health & Family Welfare) will provide overall leadership to the program. Similar to central arrangements, she/he will be assisted by the Secretary/Commissioner (Family Welfare), designated as ex-officio Project Director with close support from the Director (Family Welfare) as Additional Program Director. The technical and program management functions would be provided by the State Family Welfare Bureau.

The Reproductive and Child Health/Family Welfare Society/any other equivalent society chaired by the Chief Secretary would continue to be the governing body at the state level. It is envisaged that the state society would not only be the conduit for fund flow, but would also be strengthened to provide technical assistance for program planning/management, finance and monitoring support, particularly in EAG states, North-Eastern states, and the states of Sikkim and Jammu and Kashmir, akin to the SIFPSA model in UP.[1] This, however, would not preclude the states from establishing other suitable modalities for providing technical assistance.

By the end of the institutional mobilization phase (IMP), it is expected that all state level societies in EAG states would be fully staffed and functional to (a) provide support for planning that conforms to evidence based priorities and contextual needs and (b) programmatic and financial monitoring to ensure that results are achieved.

States would be responsible for providing an enabling policy framework for PIP and overseeing all aspects of planning and implementation. State program planning would include developing a state PIP reflecting local needs, providing training to personnel at the sub-district level and below to carry out local community needs assessment; providing assistance to districts to develop their plans, analyzing and collating the plans to determine resource requirements, encouraging inter-sector coordination among other departments. In addition, they would develop an implementation framework for intra/inter departmental and donor convergence.

[1] A registered society, the State Innovations in Family Planning Services Project Agency, SIFPSA, was set up under the Innovations in Family Planning Services (IFPS) Project funded by USAID in Uttar Pradesh, to provide flexibility in the flow of funds from the GoI. SIFPSA is responsible for the day-to-day coordination and management of all project activities and evolves partnerships with the private and public sectors for the implementation of specific strategies.

As the RCH program will be an important component of the recently approved NRHM, states would also need to assess the institutional implications of NRHM for the RCH program during the IMP, which will address, among other issues, the structure and functions of the directorates of Health and Family Welfare. Closer coordination between the directorates would be necessary to address issues of human resources (HR) management, equity and pro-poor policies and gender responsiveness. In the medium-term, the integration of centrally sponsored schemes and the state health system would also need to be addressed.

3.2.1 State Functional Analysis

3.2.1.1 State Program Planning

- Develop a balanced PIP congruent with the national PIP to meet local needs.
- Establish state and district planning cells, drawing on local expertise.
- Provide training to personnel at the sub-district level and below to carry out local CNAA.
- Assist the districts in preparing their plans and provid them with a framework for developing the plans in a participative manner and ensure ownership at the different levels. The participation needs to be at the community level involving PRIs.
- Analyze and collate district plans and estimate resource requirements.
- Disseminate the state PIP and review and re-plan annually.
- Develop a planning calendar to assist districts prepare their plans and receive uninterrupted resources.
- Encourage inter-sectoral coordination among other departments.

3.2.1.2 District Level Planning Facilitation and Monitoring

States will identify district facilitators responsible for a group of districts. Their role will be the exact state level equivalent of the role of the state facilitators (section 3.1.1.3) and are not duplicated here. The areas of their responsibility will fall into the same functional groups:

- Facilitating district planning
- Assisting preparation of state PIP
- Technical, finance, training and support service assistance to the districts

The district level issues for capacity strengthening will be initiated in all districts with special focus on the districts which report high fertility and other adverse reproductive and child health indicators.

3.3 Implementation at District Level and Below

At the district level, under the overall leadership of the Chair person of Zila Parishad/Collector, the Chief District Medical Officer (CDMOH), the Additional District Medical Officer (ADMO), Family Planning-RCH, would provide direct supervision to the program.

For technical and program management functions, the district leadership will be supported by the District Family Welfare Bureau. Key functions at this level would involve the development of district action plans ensuring appropriate stakeholder and community participation, management of human resources, infrastructure, equipment, supplies and consumables or monitoring and supervision. The district RCH and FP society/any other equivalent society would be the governing body, chaired by the

District Collector, while the CMOH would be the member secretary and ADMO (FP-RCH) the convener. It has been agreed that the district RCH societies would fulfill both implementation as well as program management support functions in EAG states. These societies are expected to be fully staffed and functional in 75 % of the districts in these states during the IMP and reach 100 % during the institutional strengthening phase (ISP). During the IMP, the district plans would be prepared, which would further strengthen state program implementation plans.

Service delivery would be ensured by sub-district structures such as community health centers, primary health centers and sub-centers. They would be responsible for providing maternal and child health care, family planning services, adolescent health care and the prevention and treatment of reproductive tract infections and sexually transmitted diseases. Since the provision of emergency obstetric care would be ensured at first referral units (FRUs), district and sub-district hospitals, it would be important for the district health authorities to be involved in the RCH program. Partnerships with the private sector would also be sought for improving access, quality, and equity of services. Similarly, primary stakeholders and PRI members will have a role in program planning, implementation, and monitoring.

3.3.1 District level functional analysis

3.3.1.1 Planning and Monitoring (a suggested district planning module has been circulated to all states)

- Establish participative planning with the community, PRIs, NGOs etc.
- Provide guidelines and develop a system for participative planning
- Develop mechanisms to develop data based planning
- Develop simplified monitoring and reporting formats to periodically measure the levels of achievements of indicators
- Design mechanisms for decentralized monitoring through the PHC/CHC
- Participate in the finalization of the district plan with the central state facilitator
- Obtain performance reports from levels below the districts level and consolidate and send them to the state level as per agreed schedules

3.3.1.2 Finance and Accounting

- Introduce the concept of budgeting as a planning function
- Liaise with district societies to obtain funds against the plan
- Build capacity to facilitate maintenance of units and accounting procedures
- Review of units financial records

3.3.1.3 Human Resource Management and Training

- Analyze the existing position and estimate necessary additional resources
- Evolve strategies to fill gaps
- Estimate capacity building requirements and accordingly develop a plan
- Monitor the effectiveness of training and maintain a training profile database
- Manage staff contracts

3.3.1.4 Vital Statistics and Evaluation

- Collect and collate data within the district
- Analyze and plan on the basis of data
- Put in place systems for the evaluation of programs at agreed intervals

3.3.2 Institutional arrangements below the district level

Institutional arrangements at the sub-district level are not described in this document. They will be the decided by the states (and districts) in the state PIPs, so that they best reflect local needs, capacities and structures.

3.4 National Health Systems Resource Center

The National Health Systems Resource Center (NHSRC) has been conceived primarily as an institution that is responsive to and is available for providing technical assistance to the center/states for building their capacity for NRHM. The goal of this institution will be to improve health outcomes by facilitating governance reform, technical innovations and improved information sharing among all stake holders at the national, state, district and sub-district levels through specific capacity development and convergence models.

3.4.1 Specific objectives

- Create a network of institutions and individuals to improve the capacity, efficiency and outcomes of health systems through meaningful interventions at the national, state, district and sub-district levels
- Develop a state of the art monitoring system based on the latest data management innovations
- Facilitate the process of accountable service delivery, community ownership and technical innovation in health systems
- Develop a framework for pro-poor innovations that reduce out of pocket expenditure and the disease burden of the poor and experiment in partnership with states and districts
- Provide an appropriate implementation framework to EAG states/districts and other backward regions/ districts through a range of non-governmental partnerships, demand side financing and improved service delivery from the public health system
- Be a focal point in the identification, documentation and dissemination of knowledge and experiences in health systems across countries and Indian states
- Provide support to MoH&FW and DoH&FW in improving health outcomes through capacity development, sharing of good practices, training and orientation. The NHSRC would evolve as a single collection point for the effective sharing of documents, reports, studies, and general information
- Provide evidence-based insights on wider determinants of health outcomes

3.4.2 Features of NHSRC

- Assist both the states and the center in institutional development for improved outcomes from RCH Phase II and beyond. Partnerships with Strategic Planning and implementation units/teams in states and districts are integral to the working of the NHSRC

- Provide timely engagement of experts/institutions for improved knowledge, capacity development including financial management, monitoring & reviews and facilitate development of capacities at the state and district levels through these processes
- Provide need-based planning and implementation support in states, working with core planning teams at the state and district levels and by a system of experience sharing and learning
- Provide useful, timely and evidence-based support for reform in the health sector to improve outcomes
- Facilitate improved program design, monitoring and evaluation
- Support initiatives for public-private partnership and other innovative experiments within the health sector

3.4.3 Short and long-term responsibilities of NHSRC

- Facilitate contracting of national and international consultants/ institutions in a short time frame to meet the needs of RCH/ state strategies, through the development of simplified and accountable procurement procedures, generic ToRs for consultants etc.
- Oversee and supervise the work of consultants so contracted
- Provide need-based support to states for the planning and management of RCH/ state health strategies
- Provide policy advice to the government
- Dissemination and effective adaptation of good practices to improve health outcomes
- Analytical work to aid the quality of joint reviews and supervision
- Provide need-based logistic support for improved governance of health sector programs
- Establish a knowledge management portfolio that is designed to meet RCH/state health strategy needs
- Above all, improve district and state management capacities in program implementation, fund management and data fidelity

3.4.4 Operational framework

An interim arrangement will be established until at least March 2006/ March 2007. The structure will comprise an Advisory Committee and a Secretariat (as resolved in the first meeting of the Advisory Committee on 9th November 2004), which will comprise of the Chief Coordinator and five or six other officials. The UNFPA, DFID and USAID have agreed to provide funds for the national requirements including long/ short-term consultants at the national level. Under USAID's and UNFPA's (DFID funds are presently parked with the UNFPA) technical assistance mechanism, a procurement agency can be contracted by each of these agencies and NHSRC will play an active role with the agencies for all its procurement activities. This arrangement will be in place at least until March 2006/ March 2007 and may continue thereafter with one or two of the development partners hosting the pool of funds for technical assistance to this sector.

4

Finance and Cost

The Government of India has approved the National Rural Health Care Mission (NRHM). The RCH Phase II essentially constitutes the Family Welfare component of NRHM. The total outlay of the MoH&FW during the Tenth Plan was Rs.26,126 crores, which was an increase of 84% over the Ninth Plan outlay. Actual expenditures during the Tenth Plan period are expected to exceed the original approved outlay. There is also a statement issued by the GoI to increase the health sector expenditure from the present 0.9% to 2%-3% of the GDP during the next five years. Taking these aspects into consideration, the total outlay for the RCH Phase II is projected to be of the order of Rs. 40,000 crores for the five year period 2005-06 to 2009-10.

4.1 Financing Arrangements

The RCH program financing is broadly categorized into two components.

1. Part A. To maintain the basic RCH program, Part A essentially finances- (a) the salaries of the core program staff in the states released through the consolidated fund of the states (Treasury) and grants-in-aid to some central institutions (b) the purchase of contraceptives for social marketing. The allocations for Part A over the five- year period, are projected to be about Rs. 20,000 crores.

2. Part B. To enable the states to design and implement the RCH Program suiting their specific needs, Part B will finance approved state plans through a flexible pool of funds. This would contribute to enhancing the quality and scope of the RCH program by supporting innovations such as public-private partnerships, demand side financing, expansion of the program to the urban poor, tribal populations and other vulnerable groups, skill enhancement of program staff and the supply of essential RCH emergency obstetric care. The polio eradication program is also included under this. Most of this money is released through state societies and the remaining is used for activities implemented by the center. Part B is also expected to be around Rs. 20,000 crores over the five-year period.

In addition to fully financing Part A from its internal resources, the GoI will also be contributing to Part B. The Department for International Development (DFID) and the World Bank has agreed to support the RCH Phase II program through pooled financing. The commitment of the World Bank is US $350 million (including USD 40 million earmarked for polio eradication and USD 20 million for retroactive financing) and that of DFID is British Pound Sterling (BPS) 265 million (excluding BPS 5 million for technical assistance which will not be included in the budget and including BPS 20 million for the year 2004-05). The UNFPA has also joined the common pool through a grant of USD 25 million.

Other development partners like the European Union and USAID will also support the program through their ongoing projects. The World Bank and other donors are also providing additional funds for the polio eradication program through separate credits. Under Part B, 70% of the expenditure of the projected outlay (excluding polio, vaccine for routine immunization, non-pool partner funding and transaction costs for sterilization incurred during FYs 2005/6 -2009/10 inclusive) is subject to the development partners' total resource commitments. The Pool's disbursements would be split pro rata between pooling partners. The DFID and World Bank financing would be over a period of five years (2005-06 to 2009-10). The World Bank is committed to finance the RCH program over a longer term based on the success of the program. Both DFID and World Bank would fianance agreed activities during 2004-05, which would be outside the pool and disbursed as per traditional SoE procedures.

Expenditure is defined as actual reported expenditure by the states and center under the program including ICB procurement confirmed by audited financial statements.

4.2 Disbursement Arrangements

The disbursement for the retroactive financing of agreed activities would be outside the pool and would be done in the traditional SoE basis and will be subject to confirmation by the audit reports as stated above.

The disbursement of pooled financing will be on an annual basis on the Financial Reports covering the previous financial year, which will include procurement contracts under ICB.

Disbursement Schedule

Expenditure Period	FMR	Disbursement in	Audit Report	Adjustment
April 04 to March 05	*	March 05 (DFID) Sept 05 (WB)	Sept 05 [2]	-
April 05 to March 06	May 31	June 06	Sept 06	June 07
April 06 to March 07	May 31	June 07	Sept 07	June 08
April 07 to March 08	May 31	June 08	Sept 08	June 09
April 08 to March 09	May 31	June 09	Sept 09	Oct 2010[3]

* For 2004-05 there will not be any FMR, but reimbursement under retroactive funding will be made as per traditional SoE procedures.

[2] Disbursement would be as per the traditional SoE submission subject to confirmation by the audit report.

[3] Any recovery arising out of the audit report would have to be physically refunded by the GoI as there would be no future disbursement against which it could be adjusted.

The Finance Management Group (FMG) within the DoH&FW will be required to provide a consolidated Financial Monitoring Report (FMR) and a consolidated expenditure report based on the individual audited financial statements from the states and the GoI with the audit observations/ disallowances. Any variances between the amount reported in the FMR and the consolidated audited expenditure report will be adjusted (recovered or reimbursed) from the next disbursement to the GoI as per the following schedule. The program expenditures reported in the FMR will be subject to confirmation/ certification by the expenditures reported in the annual audit reports of the implementing states and the GoI.

Financial management

At the national level the finance function has been outlined in Chapter 3, which provides details on institutional arrangements. The following institutional structure will be established which will be called the Finance Management Group (FMG).

- The post of Director, RCH (Finance) has been established as part of the RCH financial management structure. The Director will be responsible for administration of the budget, accounting, financial administration and capacity building of the finance set up at the center.
- The Director, RCH (Finance) will be supported by consultants (staff with experience in finance and accounts such as officers from the organized Finance and Accounts Services of GoI, qualified Chartered Accountants or Cost Accountants) who will provide assistance to this position along with undersecretaries/ accounts officers and secretarial staff. A post of an EDP manager will also be created with supportive data management staff to handle e-coding of the finance management functions.

The Director, RCH (Finance) and consultants have already been placed within the FMG.

The functions of the FMG will be as follows:

- Process all the fund releases to the states
- Monitor submission of Statements of Expenditure (SoEs)/ financial reports
- Monitor submission of utilization certificates
- Compile various MIS
- Monitor financial performance indicators
- Obtain reimbursements from the funding development partners
- Oversee the audit arrangements of the Societies for Voluntary Action (SCOVAs)
- Monitor submission of audit reports in a timely manner
- Release of advance to the National Procurement support agencies and adjustments thereof
- Adjustment from plan to non-plan
- Monitor the performance of the banks accredited under e-banking arrangements
- Interact with the state facilitation officers and the Program Management Group (PMG) on a state to state basis
- Closing and reconciliation of the accounts of RCH Phase I
- Training of financial and accounting personnel of states/districts

Finance and accounting manual

The financial systems adopted by the different reporting units will have to be uniform and hence to guide these units about the requirements, procedures, reporting formats and time frames for their submission, an accounting manual has been designed. The manual also identifies the complete process of accounting as well as detailed books of accounts and the methods to maintain them. This manual is annexed as **ANNEXURE A**.

4.3 Funds Flow Arrangement for RCH Program and Management of Funds

There are two routes through which the MoH&FW, GoI transfers funds to the state/Union Territory governments for implementation of the RCH program. Funds mainly for salary and grants-in-aid to institutions and purchase of contraceptives for social marketing are routed through state treasuries, while funds for other activities and a few selective components are provided through the State Committee on Voluntary Action (SCOVA) / state RCH /FW/Health Society, most of the funds for the day-to-day running and implementation of the RCH program are passed on to these societies directly by the MoH&FW, GoI.

Budgeting and planning

To implement and monitor the activities during the year, each implementing agency in the state (i.e., SCOVA and the District RCH Society) is required to prepare a plan of action (Annual Work Plan) indicating, inter-alia, the physical targets and budgetary estimates. The action plan will be in accordance with the approved pattern of assistance under the scheme, covering all aspects of the program activities for the period from April to March each year, and has to be sent to the MoH&FW for approval well before the start of the financial year. The action plan, which will form part of the state PIPs, should be realistic and correlate the financial and physical terms.

From the financial year 2005-06 onwards, funds for RCH related activities would be released from the MoH&FW to SCOVAs based on the approved PIPs by way of a flexible pool fund and to the district RCH Societies by the respective SCOVA societies based on their District Plans. A Budget Receipt and Control Register is required to be maintained at the state SCOVA and district RCH Societies in the format given in Appendix-1 of the Finance and Accounts Manual in order to keep a record of the total budget proposed, budget approved, funds received and released advanced, etc. at one place.

Flow of funds

The GoI, MoH&FW would be providing the funds to SCOVAs through its budgetary resources.

Funds of the state committee on voluntary action (SCOVA)

- The funds of the SCOVAs would consist of grants-in-aid made by or through the GoI, MoH&FW , or the state government.
- All funds received by way of grants, gifts, donations, and benefactions, transfer and in any other manner from any source other than the government.
- Interest accrued on the grants-in-aid received or deposits.
- The unspent balances lying with the SCOVAs as on 31st March 2005, i.e., the date of closure of RCH, Phase I, will be merged with the funds for the RCH Phase II Program be launched on 1st April 2005.

Frequency of fund release and conditions precedent

Based upon the approval of the PIPs and Annual Work Plans (AWPs) of the States/UTs by the National Program Co-ordination Committee (NPCC), and the submission of the Letter of Undertaking/Understanding by the states/UTs, the first tranche of funds will be released in the first year, which will be 50 % of the first year's requirements. The release of the second tranche of funds from the MoH&FW, GoI in the first year will be made subject to the fulfillment of financial management indicators relating to *HRD* and *Empowerment* (parts A and B of Financial Management Indicators). The fulfillment of all financial management indicators (Parts A, B and C of FM indicators) would be necessary for the release of funds in the second and subsequent years. In addition, from the second year onwards it will be necessary for the states/UTs to sign a Memorandum of Understanding with the MoH&FW, GoI and the achievement of at least half the institutional process targets specified in Appendix III of the MoU to access further funds. The NPCC will determine the value of releases from the fiscal year 2008/09 onwards in the light of the state/UTs achievement of the output targets specified in Appendix III (b) of the MoU, as verified by means of a Mid-Term and End-Line survey.

Funds will be released biannually, subject to the above mentioned conditions precedent.

Utilization of funds

Under RCH Phase I it has been observed that in many states/ UTs, the level of fund utilization has not been satisfactory. While many reforms have been attempted during the implementation phase to increase the level of utilization, it has not shown results in the poor performing states/UTs. Hence, the main focus of the MoH&FW under RCH Phase II is to increase the absorption capacity of such states and UTs. While all attempts are being made to strengthen the program management units at the state and district levels, it is felt that it is better financial management practices which will ultimately help the management aim for greater absorption capacity within the system. The accounts and finance personnel, thus, have a very vital role in the overall scheme of things under the RCH Program.

Maintenance of funds by state SCOVA society

All money credited to the funds of the Society under the RCH Program shall be deposited in a savings bank account of a scheduled bank approved by the MoH&FW, GoI. The societies having an account with the existing bank may continue unless otherwise intimated by the GoI. For the speedy release of funds from the center to the states/UTs and from the states to the districts, an e-banking solution is likely to be introduced soon by the MoH&FW, GoI. The guidelines for the same have been provided in 4.5. Societies shall maintain proper/separate books of accounts in respect of funds received under other bilateral projects viz. EC funded SIP, USAID, etc., under the RCH Program.

Maintenance of Accounts

The accounts of the societies shall be maintained as per double entry book keeping principles, on cash basis of accounting. Standard books of accounts (Cash Book, Journal, Ledger, etc.) shall be maintained as per consistently applied accounting standards of the Institute of Chartered Accountants of India (ICAI).

A record of all program transactions shall be maintained with appropriate supporting documentation for the transactions. These supporting documents should be cross-referenced so as to link them to each item of expenditure with budget heads, project components, expenditure categories (summary and detailed) and disbursement categories and compatible with the classification of expenditure and sources of funds indicated in the project accounts together with supporting documents. Project management

reports should be maintained for at least three years after the completion of an audit of the entire program expenditure, i.e., at least three years after the completion of the RCH Phase II.

In order to keep proper financial information on the project activities, the standard ledger heads for each component and sub-ledger heads for all the categories under these components shall be maintained. All expenditure incurred by a society shall be booked under the account heads maintained in respect of various items of expenditure relating to these components. A statement of ledger account heads is indicated in Appendix-3 of the Manual. Detailed procedures and guidelines for maintenance of books of accounts at the District RCH Societies and state SCOVA are given in Chapter III of the Manual.

Submission of financial reports

All the districts would send a monthly SoE to the state SCOVA by the 10th of the following month in respect of expenditure incurred by them as per the format given in Appendix-4 of the manual. In case the information is not received from the districts by the10th, the state SCOVA will immediately contact the district RCH Society/ CMO to have the information expedited. In some cases concerned district officials may have to be asked to personally bring the information to ensure compliance. In case, districts neither furnish the information nor bring the information personally, state officials may be deputed to look into the problems faced by the district in providing the information and set them right.

A format of the SoE, which is required to be furnished within 30 days from the close of each quarter, by the State SCOVAs to the center, is given in Appendix-5 of the manual. As stated in the above para, the state SCOVA must ensure the receipt of information from all the districts, compilation, and furnishing of the same to the MoH&FW, GoI within the stipulated dates without fail.

The dates for the different quarters by which the financial reports should be submitted to the MoH&FW, GoI are as under:

	Quarter	Due Date
1.	First Quarter (April-June)	31st July
2.	Second Quarter (July-September)	31st October
3.	Third Quarter (October-December)	31st January
4.	Fourth Quarter (January-March)	30th April

Procedure for utilization of funds

- The Society funds shall be drawn through cheques and/or bank drafts.
- All cheques shall be signed by two signatories of the Finance and Administration Division, authorized by the Governing/Executive body of the Society, on the basis of a written authorization from the concerned Program Manager/ Consultant and/or Head of concerned Division and/or Executive Director and / or Director Health Services.
- Wherever it is decided that the release is to be made through bank drafts, the concerned authorized signatories shall sign the authorization letter to the bank.
- In case electronic banking (e-banking) is introduced by the GoI for fund release and day-to-day payments for program implementation, separate detailed guidelines will be issued by the GoI for effecting fund transfer and the execution of payments.

- In all cases where funds are to be released on the basis of approved plans, the concerned program manager shall prepare a 'request for release' proposal for the issue of a cheque/draft by the Finance and Administration Division. The 'request for release' shall be routed to the Finance and Administration Division through the concerned Head of Division and shall be accompanied by (a) a copy of the agenda papers of the relevant meeting of the Governing Body/Executive Body and (a) a copy of the minutes of the relevant meeting indicating approval of the proposals.
- In all other cases, proposals shall be initiated by the concerned division and sent to the Finance and Administration Division after obtaining the approval of the appropriate authority, depending on the sum involved.

Review / revision of financial powers

The governing body may review and revise the financial powers of the office bearers of the bodies of the society on an annual basis and revise the same, if considered necessary.

Utilization certificate

In respect of the grant-in-aid received from the GoI, the society shall furnish a "Utilization Certificate" (UC) in Form No. GFR 19A duly signed by the Project Director to the MoH&FW, GoI along with the audited annual financial statements. A copy of the format of Utilization Certificates is given in Appendix-6 of the Manual.

All grants-in-aids sanctioned and released by the GoI to SCOVA in a particular financial year shall be indicated by the society in its UC of that financial year, irrespective of the fact that it is received by the society in the subsequent financial year.

Delegation of financial powers

To ensure smooth, fast and efficient utilization of funds for the purpose (s) for which these are released by the GoI, it has prescribed a model delegation of Financial and Administrative Powers to state/UT governments which is a part of the Finance and Accounts Manual for the RCH Phase II. The states and UTs are required to delegate such powers to state SCOVAs and District Health/RCH Societies before the release of the second tranche of funds in the first year itself.

The society shall function on the basis of the delegation of such financial and administrative powers, which have been delegated by the Governing/ Executive Body of the Society or through the Government Order of the state/UT government.

Miscellaneous

The income and property of the Society, howsoever derived, shall be applied towards the promotion of the objectives thereof, subject nevertheless to financial discipline in respect of the expenditure of grants imposed by the central government from time to time.

If on the winding up or dissolution of the Society there shall remain (after satisfaction of its debts and liabilities), any property whatsoever, the same shall not be paid to or distributed among the members or any of them, but shall, consistently with the objectives of the Society, be dealt with in a manner determined by the central government.

Performance-based financing

It was agreed that a performance-based financing (PBF) scheme would be introduced into the flexible funds, which would be tied to good performance by each state. Linking financing to performance facilitates will lead to the introduction of a new result-oriented accountability into an input-oriented public system. Through variable financing the proposed scheme would seek to influence central government allocation behavior to the extent that a proportion of future allocations to the states is based on results.

A state would be deemed to have earned its performance award for a given year if it had attained or exceeded the set of targets/benchmarks, which would have been set for each state, by agreement between the GoI and the respective state. Performance awards (comprising 10% of the annual budget for the given fiscal year) would fund activities in the state PIPs of the subsequent year, over and above what the respective state would have received in flexible funding. Different criteria would be developed for the EAG, North Eastern states and other states. The awards would commence in the second year of the program (2006/07), based on performance during the first year (2005/06).

Letters of Undertaking and Memorandum of Understanding

The PIP from each state/ UT would be appraised by an Appraisal Committee set up at the level of the GoI, which would place its recommendations for the release of resources to the states for each such state/ UT to the IFD/ Secretary/National Program Implementation Committee. The states would initially submit a Letter of Undertaking as in RCH Phase I and within a year of the launch of the program execute a MoU with the MoH&FW. The sample Letter of Undertaking and the MoU are attached as **ANNEXURE B**.

Based on its PIP and log frame, each state would set its own annual level of achievement for the core program indicators and these would be included in the MoU. Subsequently, states will have similar arrangements with the districts.

The mandatory core financial and program indicators are given in Appendix II and Appendix III (a) and III (b) of the MoU respectively. The Financial Manual outlines the desired delegation of financial and administrative powers as well as the financial reporting format for the program purpose.

A performance-based management arrangement shall apply to the release of flexible pool resources, with reference to the milestones in Appendix II and III of this MoU. The milestones in Appendix III are institutional process indicators and will be subject to annual revision. The indicators in Appendix III (b) are output indicators and these will be reviewed on the basis of mid term and end line surveys (RHS) organized by the MoH&FW.

The signing of the MoU between the MoH&FW and the states within a year of the launch of the program is a necessary condition for all subsequent releases of flexible pool resources. The value of all releases would be positively related to prior expenditure.

4.4 RCH Phase II Program Costing for 2005-10

Ministry of Health & Family Welfare

National Family Welfare Program Budget (In Rs. Crore at nominal values)

S. No.	Scheme Title	Budget Head Title	2002-03 Actuals	2003-04 Actuals	2004-05 RE	Projected Expenditure (Rs. crore)							Financing Plan			
						2005-06 BE	2006-07 Proj.	Total 2005-06+ 2006-07	2007-08 Proj.	2008-09 Proj.	2009-10 Proj.	Total RCH Phase II	GoI	World Bank/ DFID	Other DP suppo-rted Projects	Total
A: Activities to be included under Domestic Budget Support																
A. 1	**Operational Support to the States**															
	1. Direction & Administration	Maintenance of State & District FW Bureau	183.43	211.96	218.94	245.80	320	600	360	400	425	**1785**	1785			1785
		POL	113.07	74.60	55.00	30.00										
		Regional Offices	4.97	3.47	3.13	3.75										
		Information Technology	—-	—	0.36	0.66										
	2. Rural FW Services (Sub-Centers)	Salary to ANM/LHVs	1848.84	1713.36	1788.21	1759.40	2250	4214	2600	3000	3200	**13014**	13014			13014
		Contingency Portion				55.00										
		Arrears				150.00										
	3. Urban FW Services	Urban Family Welfare Centers	103.39	121.52	122.84	71.53	150	285	175	200	220	**880**	880			880
		Urban Revamping Scheme (Health Posts)				63.80										

Contd...

S. No.	Scheme Title	Budget Head Title	2002-03 Actuals	2003-04 Actuals	2004-05 RE	Projected Expenditure (Rs. crore)							Financing Plan			
						2005-06 BE	2006-07 Proj.	Total 2005-06+ 2006-07	2007-08 Proj.	2008-09 Proj.	2009-10 Proj.	Total RCH Phase II	GoI	World Bank/ DFID	Other DP suppo-rted Projects	Total
	4. Grants to State Training Institutions	Basic Training for ANM/LHVs	62.44	68.03	71.42	77.73	120	227	130	140	150	**647**	647			647
		Maint. & Strengthening HFWTCs	13.41	14.25	14.38	16.84										
		Basic Trg. for MPWs (Male)	9.16	8.56	9.20	10.15										
		Strengthening of Basic Trg. Schools	0.22	1.83	3.06	2.15										
	5. Free Distribution of Contraceptives	Free distribution of contraceptives	153.92	141.42	93.19	172.52	200	373	250	275	300	**1198**	1198			1198
	6. Sterilization	Sterilization beds	1.76	1.97	2.02	2.02	2	4	5	5	5	**19**	19			19
	7. FW linked Health Insurance Plan	FW linked Health Insurance Plan	—-	—-	4.00	35.00	40	75	50	60	70	**255**	255			255
	National Population Stab. Fund/NCP	National Population Stab. Fund/NCP	—-	100.00	—-	10.00	10	20	15	17	20	**72**	72			72
	Sub-Total A.1.		**2494.61**	**2460.97**	**2385.75**	**2706.35**	**3092**	**5798**	**3585**	**4097**	**4390**	**17870**	**17870**	**0**	**0**	**17870**

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S. No.	Scheme Title	Budget Head Title	2002-03 Actuals	2003-04 Actuals	2004-05 RE	Projected Expenditure (Rs. crore)							Financing Plan			
						2005-06 BE	2006-07 Proj.	Total 2005-06+ 2006-07	2007-08 Proj.	2008-09 Proj.	2009-10 Proj.	Total RCH Phase II	GoI	World Bank/ DFID	Other DP suppo-rted Projects	Total
A.2	**Operational Costs of Institutions & other Committed Expenditure (Central Sector Schemes)**															
	Social Marketing of Contraceptives	Social marketing of contraceptives	98.87	141.70	242.06	241.04	250	491	275	305	310	**1381**	1381			1381
	Social Marketing Area Projects	Social Marketing Area Projects	—-	—-	—-	10.00	10	20	12	15	15	**62**	62			62
	Grants-in-aid to other institutions	FWTRC, Mumbai	0.98	0.20	0.56	1.00	70	125	80	90	100	**395**	395			395
		NIHFW, New Delhi	2.60	4.00	4.62	7.35										
		IIPS, Mumbai	1.70	1.15	1.35	1.65										
		RHTC, Nazafgarh	—-	—-	3.67	3.98										
		Gandhigram Institute	—-	—-	0.91	—-										
		Population Research Centers	5.71	5.85	7.20	7.30										
		CDRI, Lucknow	2.30	1.15	2.30	2.75										
		ICMR and IRR	20.00	27.00	30.00	30.00										
		IMA	—-	0.25	0.25	0.30										
		Testing Facilities	0.38	—-	0.45	0.45										

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S. No.	Scheme Title	Budget Head Title	2002-03 Actuals	2003-04 Actuals	2004-05 RE	Projected Expenditure (Rs. crore)							Financing Plan			
						2005-06 BE	2006-07 Proj.	Total 2005-06+ 2006-07	2007-08 Proj.	2008-09 Proj.	2009-10 Proj.	Total RCH Phase II	GoI	World Bank/ DFID	Other DP suppo-rted Projects	Total
	Other Operational Expenses	Travel of experts / conferences/ meetings	0.47	0.20	1.00	3.50	10	19	12	15	20	**66**	66			66
		International Co-operation	1.34	1.39	1.25	1.70										
		Expenditure at Headquarters	1.24	2.11	3.00	3.50										
	Sub-Total A.2.		**135.59**	**185.00**	**298.62**	**314.52**	**340**	**655**	**379**	**425**	**445**	**1904**	**1904**	**0**	**0**	**1904**
TOTAL A (DBS)			**2630.20**	**2645.97**	**2684.37**	**3020.87**	**3432**	**6453**	**3964**	**4522**	**4835**	**19774**	**19774**	**0**	**0**	**19774**
B. Activities to be included under EAP																
B.1	**Activities implemented by MoH&FW**															
	8. Procurement of Supplies & Materials	Drug & Equipments (Other than Vaccines)	121.96	109.29	110.59	250.00	300	550	325	350	360	1585			——	1585
		Laparoscopes	—-	1.31	—-	—-										
	9. Routine Immunization	Vaccines for routine immunization	96.11	126.72	107.00	150.00	550	1057	610	650	650	2967			——	2967
		Hepatitis vaccine	0.48		15.50	10.00										
		Needles and syringes	—-		12.00	124.00										
		Neo-natal equipment	—-		2.00	6.00										

Contd...

S. No.	Scheme Title	Budget Head Title	2002-03 Actuals	2003-04 Actuals	2004-05 RE	Projected Expenditure (Rs. crore)							Financing Plan			
						2005-06 BE	2006-07 Proj.	Total 2005-06+ 2006-07	2007-08 Proj.	2008-09 Proj.	2009-10 Proj.	Total RCH Phase II	GoI	World Bank/ DFID	Other DP suppo-rted Projects	Total
		Cold chain equipment	11.92		26.20	40.00										
		RI strengthening project	4.10	0.89	3.00	173.00										
		Cold chain maintenance	2.50		1.80	4.00										
	10. Polio Eradication	OPV for PPI	432.11	659.94	905.10	563.00	510	1387	350	400	400	2537	**11958**	**3775**	2537	2537
		Pulse Polio operating costs				314.00										
	11. Behavioral Change & Communication	BCC/IEC	84.07	91.95	161.08	124.10	150	279	200	250	275	1004			——	1004
		Adolescent Health	—-	0.60	5.00	5.00										
	12. Training	RCH training	6.58	19.56	18.07	30.93	35	66	40	50	50	206			——	206
	Monitoring & Evaluation	MIS	15.18	7.41	5.51	8.00	10	18	15	20	20	73			——	73
	NGOs (Public-Private Partnerships)	NGO/SCOVA/PPPs	17.79	18.04	—-	102.70	110	213	120	130	130	593			——	593

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S. No.	Scheme Title	Budget Head Title	2002-03 Actuals	2003-04 Actuals	2004-05 RE	Projected Expenditure (Rs. crore)							Financing Plan			
						2005-06 BE	2006-07 Proj.	Total 2005-06+2006-07	2007-08 Proj.	2008-09 Proj.	2009-10 Proj.	Total RCH Phase II	GoI	World Bank/ DFID	Other DP suppo-rted Projects	Total
	New Initiatives	Technical Assistance	—-	—-	—-	—-	5	5	10	15	15	45			——	45
		Policy Development & Pilots	2.95	42.01	3.00	—-	4	4	6	8	10	28			——	28
		Implementation of PNDT	2.15	—-	—-	—-	—-	—-	—-	—-	—-	—-			——	—-
		Other innovations/ intervention	—-	—-	—-	—-	5	5	10	15	15	45			——	45
	Sub Total B.1		**797.90**	**1077.72**	**1375.85**	**1904.73**	**1679**	**3584**	**1686**	**1888**	**1925**	**9083**			**2537**	**9083**
B. 2.	**Activities in the State PIPs**															
	13. Other Externally Aided/Area Projects	**IPP Projects**	58.86	34.96	39.87		300	836	350	370	400	1956			1956	1956
		UNFPA assisted projects				35.60										
		Other assisted projects				12.80										
		Counterpart Domestic Component				1.86										
		USAID assisted projects	40.24	55.00	47.36	50.00										
		EC assisted SIP project	43.39	163.62	300.00	436.00										

Contd...

S. No.	Scheme Title	Budget Head Title	2002-03 Actuals	2003-04 Actuals	2004-05 RE	Projected Expenditure (Rs. crore)							Financing Plan			
						2005-06 BE	2006-07 Proj.	Total 2005-06+ 2006-07	2007-08 Proj.	2008-09 Proj.	2009-10 Proj.	Total RCH Phase II	GoI	World Bank/ DFID	Other DP suppo-rted Projects	Total
	14. RCH Flexible Pool for State PIPs	RCH flexible pool for States	346.04	420.25	852.55	962.14	1500	2462	1800	2000	2100	8362				8362
	Activities supported by performance awards		—-	—-	—-	—-	165	165	200	220	240	825				825
	Sub Total B.2		**488.53**	**673.83**	**1239.78**	**1498.40**	**1965**	**2627**	**2350**	**2590**	**2740**	**11143**			**1956**	**11143**
	TOTAL B		**1286.43**	**1751.55**	**2615.63**	**3403.13**	**3644**	**6211**	**4036**	**4478**	**4665**	**20226**	**11958**	**3775**	**4493**	**20226**
	TOTAL PROGRAM EXPENDITURE (A+B)		**3916.63**	**4397.52**	**5300.00**	**6424.00**	**7076**	**13500**	**8000**	**9000**	**9500**	**40000**	**31732**	**3775**	**4493**	**40000**

4.5 The E-Banking Route: RCH Phase II Financial Management Solution

Tracking of funds given to the states and Union Territories (UTs) by the Union Government has been a major problem in almost all the programs and projects. The RCH Program has not been an exception. To monitor the fund utilization status, the MoH&FW has to wait for the quarterly SoE from the states, which more often than not are delayed for months. Even if they come, the system is inundated by the sheer number of papers and the amount of work required in putting the information in a meaningful format. In the process, precious time is lost and the MoH&FW is at best able to compile a delayed status report of program implementation. In the cycle of delay, the opportunity to push for a mid-term correction for greater absorption of available resources is lost.

To address this problem it was realized that faster means of determining the fund utilization status at each level was a must. Towards this goal the e-banking solution takes up the issues of fund flow as well as availability of on-line status of fund utilization at each level through a novel and innovative system, which can be put in place in a relatively short span. This would be a major step towards sector reform in the area of financial management.

The strategy

The MoH&FW thought of inducting new generation technology driven bank(s)[2] for electronic fund transfer to the states/districts, who will be asked to compile head-wise preliminary accounts, while providing normal banking functions for the money disbursing/expenditure making entities. After an evaluation of several banks, the job of providing the e-banking solution has been entrusted to a leading private sector bank on a pilot basis. In the pilot phase the states of Goa, Kerala, Gujarat, Jharkhand, Uttaranchal and Rajasthan have been taken up. Once the pilots are completed successfully, the scope of e-banking will be expanded to cover all the states and UTs where the funds are routed through the SCOVA mechanism.

Enabling steps

- The bank will open accounts for all the concerned entities such as the MoH&FW (or the concerned divisions), NIHFW, IIPS, state SCOVAS and district RCH societies.
- Wherever the bank has a branch at the location, it will open an account for the entity at the local branch. In those districts where the bank does not have a presence, SCOVAs will open accounts in the branch situated in the state capital where the state SCOVA has an account.
- The bank will give Internet facility to all concerned entities.
- Access may be qualified through a digital signature or other security features provided by the chosen bank.
- These banks are also in a position to provide for multi-layer e-signatories for greater security. This will basically replicate the requirement of more than one signature on cheques in the manual system.

[2] Banks have their back-office data processing centralised at one place (called HUB) and branches all over the country connected to this hub as satellites. This enables them to provide anywhere banking on the principle of "geography is history." A central database of all transactions facilitates them to provide web enabled customized solutions for specific users.

- All the entities will be provided with computers, modems and Internet connectivity.[3]
- Multiple dial-up Internet connectivity will be procured from different ISPs as back up for each other.
- For continuous power requirement, it has been ascertained that each CMO in the districts has a generator, which was provided for cold chain maintenance.

The transactions and expenditure accounting will take place in the following manner using these screens given below as a data exchange interface.

Screen-1: Screen/Format for Intimation to Bank for Grant Release to States

MoH&FW GRANT RELEASE ADVICE TO BANK

- **Name of the Division :** Drop Down menu
- **Sanction No.** _____ **Date :** _____
- **Item of Expenditure** Drop Down menu
- **Type of Grant** ☐ **Recurrent** ☐ **Non-recurrent**
- **Name of the SCOVA :** _____ **Amount :** _____
- **UC Due Date :** System Generated
- **Transaction ID :** System Generated

Alternatively, the Divisions can provide this data on floppy to the PAO, who can upload it or send it to the nodal branch of the bank for uploading it.

[3] Under the CNA Program, the MoH&FW with the help of the NIC has provided 530 computers to the District FW Offices along with modems. According to NIC, Internet connectivity in district towns is not an issue at all, as almost all of them have multiple ISPs providing good enough bandwidth for our requirement, which is presumed to be intermittent and requiring a small bandwidth.

Preliminary discussions with some SCOVA functionaries as well as AFF have also confirmed this hypothesis by revealing that typically a state SCOVA will have only around 150-175 transactions with the bank in a year, while the district SCOVA will have around 25-35 per month.

Screen-2: Screen/Format for Transferring Money to District RCH Society by State SCOVA

ACCOUNT TRANSFER TO:

- **Name of the Distt. SCOVA :** Drop Down menu
- **Item of Expenditure :** Drop Down menu of 34/35 Items
- **Sanct. No. of GoI :** Drop Down menu **Date :** Sys Gen
- **UC Due Date :** System Generated **Amount :**
- **Transaction ID :** System Generated

Screen-3: Screen/Format for Making Payment or Advances to Parties/Agencies

PAYMENT TO/ACCOUNT TRANSFER TO:

☐ **Payment to Party/Agency** ☐ **Advance***

- **Mode of Payment :** ☐ **A/C Transfer** ☐ **Draft** ☐ **Cheque****

  ↓

  A/c No.

- **Item of Expenditure :** Drop Down menu of 34-35 items
- **Sanction No. of GoI :** Drop Down menu **Date :** System gen.
- **Sanction No. of State :** **Date :**
- **Amount :**
- **Name and Address of the Party/Agency :**
- **UC Due Date :** System Generated
- **Transaction ID :** System Generated

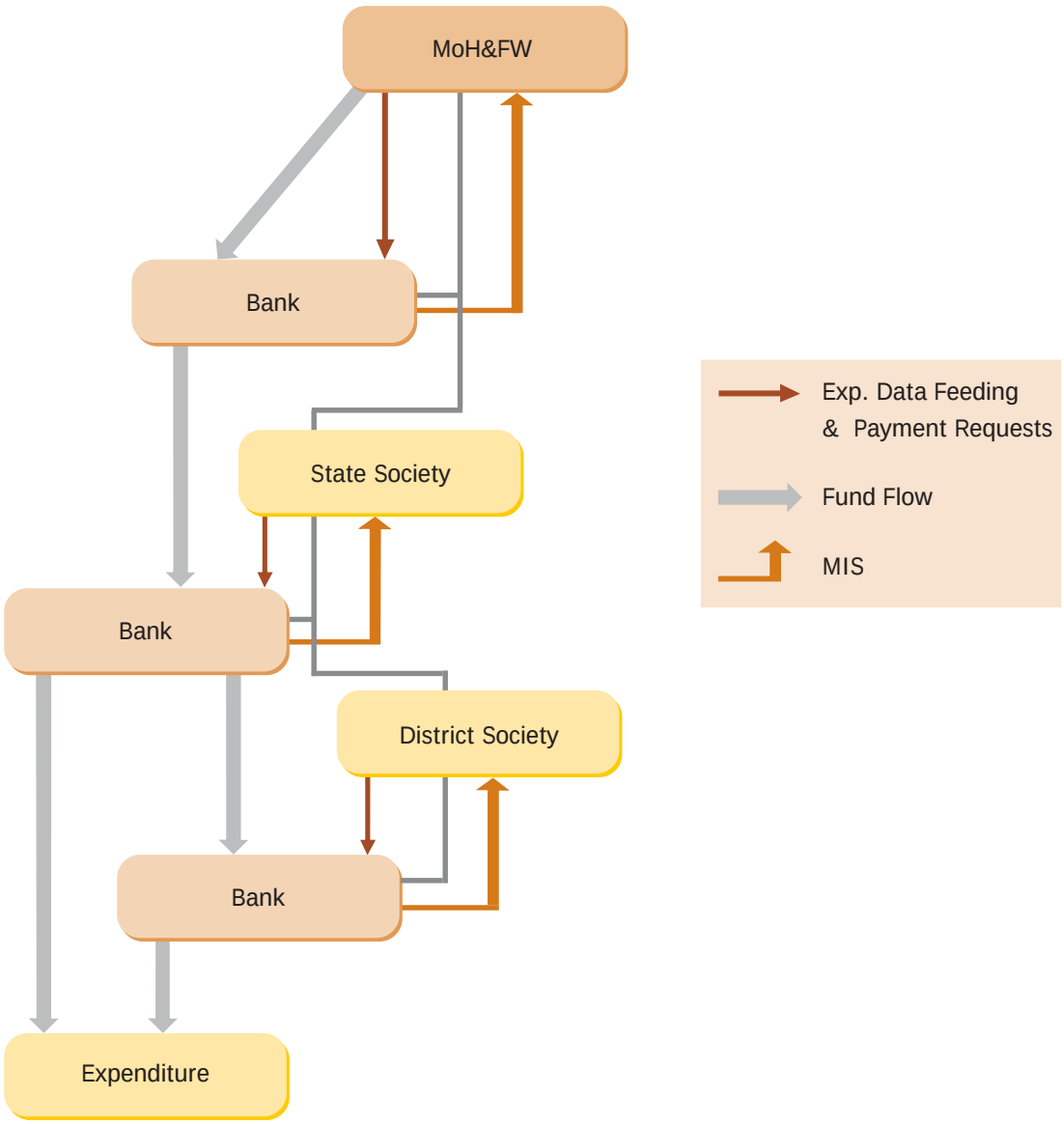
---

* **In case of advance please note that MoH&FW, GoI will not treat it as expenditure unless the final accounts are submitted as proof of utilization of the advance.**

** **In case of payment by cheque, please enter all the above details along with the following details :**

Cheque No. | Date

Process Flow



- Through Internet, all the concerned entities viz. MoH&FW, state SCOVA and the district RCH Society will log on to the bank's server.
- Through **SCREEN-1** the MoH&FW, GoI will transfer the grant to the state SCOVA. (Alternatively, the MoH&FW can even transfer the funds directly to the district RCH Society, either 100 percent or a certain percentage of its requirements, the rest being given to the state SCOVA as reserve.)
- Through **SCREEN-2**, the state SCOVAs will transfer the funds to the respective district RCH societies.
- Using **SCREEN-3,** the district RCH Societies will advise the bank to incur the expenditure on its behalf and at the same time help the bank compile preliminary accounts of expenditure. **This screen will also be used by the state SCOVAs for the expenditure which they incur at their level.**

There are three modes of payment available:

- **Account Transfer:** If the parties who regularly supply services or goods for the activities open their accounts in the same bank, this can be the ideal mode of payment.

  This mode of payment will be location independent and, thus, those district RCH Societies who have their accounts in the bank branch at the state capital (due to unavailability of a bank branch at the district), can also use it without any difficulty.

- **Bank Draft:** A large number of payments are made by the SCOVAs through drafts. This mode of payment is also location independent, and hence can be used by both the SCOVAs having local as well as outstation bank branches.

  After the SCOVA authorizes the bank to make a payment by draft, the bank will issue the draft, which can be sent to the SCOVA for posting it to the beneficiary. **Better still, the bank can send the draft directly to the beneficiary since the SCOVA would have provided the address of the party through this screen.** An intimation that the draft has been issued will come to the SCOVA. The postal charges can be settled between the bank and the SCOVA.

  The bank may agree to issue drafts at par.

- **Payment through Cheque:** A major part of payments will still be made through cheques. However, banking regulations allow the banks to issue cheques on behalf of the account holders in the same manner as in the case of bank drafts. Thus, the issue of cheques will also follow the business process as in the case of drafts.

- **Advance Payment:** District RCH Societies provide a sizable amount as advance to many agencies/ parties (such as PWD) for construction purposes or for holding of camps, etc.

  Such advances whether paid through account transfer, Demand Draft or cheque, as can be seen from the SCREEN-3 above, will be separately captured to be kept aside in the banking database in the transitory table **EAT**, as in the case of payment by cheque. Their transfer to the **SoE** Table will take effect in the following simple manner:

Screen-4: Screen/Format for Uploading the SoEs in Lieu of Advances Given by the Society

SoEs RECEIVED FROM PARTIES/AGENCIES

- **Transaction ID :** _____
- **Name of the Party/Agency :** System Generated
- **Advanced :** System Generated
- **Shift the Advance to SoE :**
  - **Entire :** **Yes** ☐ **No** ☐
  - **If No, Please fill in the amount for which SoE has come :**

    Rs. _____

- Once the party/agency to whom advances were paid sends in the SoE, using this screen the SCOVA will transfer the amount advanced earlier from the EAT Table to the SoE Table of the banking database.
- Once the **Transaction ID** generated at the time of giving the advance in SCREEN-3 is entered, the **name of the party/ agency** and **advance** amount will get generated automatically.
- The SCOVA can shift the entire advance maintained in the EAT Table of the bank to the SoE Table of the bank, if the party/agency has given the accounts of utilization for the entire advance. If partial accounts of utilization have come, the SCOVA will be able to transfer the partial amount from EAT to SoE using this screen. The balance amount for which the utilization account has not come will remain pending in the EAT Table for transfer to SoE Table at a later date.
- **This procedure will complete the entire accounting process of a society in particular and the scheme as a whole.**

Atypical issues

- **Issue of district RCH societies having a bank account in the state capital:** In the cases of payment through account transfer and bank draft these SCOVAs will not face any problem, as these modes of payment are location independent. However, in the case of payment through cheques, they will issue 'outstation' cheques, which may take an additional day or two for realisation.

  For their day-to-day cash requirements and imprest management, these SCOVAs will be allowed to open a bank account in a nearby branch of any bank. They can transfer money to this bank account by issuing a cheque of the accredited bank through e-banking by categorising it under **'ADVANCE'** in SCREEN-3 above. ***An ATM based solution for immediate petty cash availability in such districts may also be a possibility. The card can be charged through e-banking using the same process as issuing a cheque.***

Banking arrangement in districts without Internet connectivity: It is expected that we will not face Internet connectivity problem in any of the districts as multiple Internet Service Providers (ISPs) like NIC, Reliance or Spectranet are expected to be present in each of the districts. However, as a contingency plan the business process for the districts not having Internet facility is outlined in **APPENDIX-A,** to build redundancy into the proposed system.

Benefits: Improved Capacity to Manage Finances

To fully appreciate the benefits of the proposed system, let us underline the problem areas of the system in use. The present system, or the lack of it, is marked by the following shortcomings.

- AFF reports that it takes around two months for the funds to reach districts. Delays at all the levels contribute towards this bottleneck. A significant amount of time is lost in the first leg itself, i.e., in the MoH&FW where the sanction is issued by the divisions; the bill is sent to the PAO by the Cash Section; the PAO sends a cheque to the accredited bank for preparation of drafts and after the drafts are received from the bank it is sent back to the concerned division for sending it on to the states.

  It takes another round of activities at the state level to finally send the money to the districts.

- Since the draft goes to the states without the sanction letter, in many cases the states/districts do not know the exact nature of the purpose for which the draft has come. This confusion, in turn, delays utilization since the society does not know under which head and to what extent the expenditure is to be made.[4]
- This vagueness also creates confusion in activity-wise accounting. As a result the quality of accounts suffers.
- There is no uniformity in accounting practices across the board. Various books of accounts and registers are not maintained uniformly in all the societies.
- Advances are mixed up with expenditure, creating problems for the MoH&FW at the time of seeking reimbursement from the World Bank. This practice is also in contravention to sound accounting principles.
- Last but not the least, the SoE and UC from the districts to state and from states to the center take a long time to come which delays the compilation of various MIS at the national level and the reimbursement from the World Bank.

Benefits:

- Disbursal of funds at all the levels will be electronic and instant.
- Funds will reach each account segregated activity-wise. There will be no confusion about the purpose of the allocated fund.
- The system will not allow expenditure in excess of the disbursed amount under any activity. This will help budgetary control.
- The system will capture allocation and expenditure:
  - Division-wise
  - Sanction Order-wise
  - Activity/Item of Expenditure-wise
  - SCOVA-wise
  - UC-due date-wise
- With different levels of selective authorization, various entities such as the Union, state or district will be able to know the financial position on-line on real time basis.
- Considering the ease of fund transfer, the Center can schedule the releases based on the time schedule of requirement indicated by states. Thus, entire funds need not be parked in the Societies' accounts at the beginning of the year.

[4] In one of the RCH Workshops at Jaipur, the Financial Consultant of the state society of Jharkhand wanted to come to the MoH&FW for activity-wise segregation of the funds lying in his bank account.

GoI Level

The MoH&FW will be able to know the level of fund utilization:

- Under a particular activity or item of expenditure under each District, State or entire nation
- Against a particular sanction order
- Against the UC due date
- Under a particular SCOVA as a whole for all the activities under it
- For the entire State as a whole
- For the entire nation for the sector as a whole

The MoH&FW will be able to take the following mid-term corrective actions:

- Giving periodic lists to the States of performing, under-performing and non-performing Districts, so that the States can focus their attention where it is needed most
- Issuing alert warning to states against the sanctioned funds nearing UC due date
- This will allow the Center to monitor the fund utilization pattern in each state and through various interventions aim for a better level of absorption capacity within the service delivery system

- **The Center may also like to go ahead with the reimbursement from the World Bank, based on the accounts available through on-line data submitted by the accredited bank, for this data is based on the information fed by the SCOVAs themselves and is firm expenditure made by such entities. The accounts prepared by the entities are not expected to differ from this data and the MoH&FW in subsequent reimbursements may adjust a negligible amount of difference, if at all. Benefits include:**
  - Better utilization of IDA committed loan.
  - Less commitment charges by GoI as committed loans will translate into a proper loan faster.
- If the interlinking between the benchmark related funding mechanism and the expenditure status provided by this system is established, it will lead to a better overall financial management system for the sector as a whole providing an excellent reviewing and monitoring tool. **This will be of special significance for the RCH Phase II as it envisages benchmark related funding, which calls for closer and constant monitoring, especially for the EAG and North East states.**
- The state can review and monitor the whole scheme, as the utilization status under each area of operation, categorised under each society will be available on-line on real time basis.
- The system will compile the expenditure of all the district RCH Societies attached to a particular state SCOVA for the latter.
- The **states** will also be able to generate **UCs** through the '**GENERATE UC'** utility. The system will fill in the funds received against a particular sanction or a number of related sanctions and pick up the expenditure data from the SoE Table of the society against those sanctions. The UC can be sent on-line or printed and sent to the GoI in the normal course or as an e-mail attachment.[5]

[5] Even if the GOI demands audited UCs, the file processing for releasing further grants may be initiated after receiving the UC through e-mail. The grant may finally be released only after the audited UC is received. However, the lead-time provided by the UC received through e-mail will ensure that the grant can be released as soon as the audited UC arrives.

State Level

The States will be able to know the level of Fund utilization:

- Under each activity against each District
- Against each district as a whole
- For the state as the sector as a whole
- UC Due date-wise

The State will be able to take midterm corrective action by:

- Reallocating funds by electronically debiting the account of those districts which are not likely to spend money under a particular activity and crediting it to a district which shows better prospects of spending it.*
- Issuing alert warning for the sanctions nearing UC Due Date

- Reconciliation between the bank and the societies, as well as among all the entities will be much simpler as the same database will be available to all.
- Once the accounting system in SCOVAs is automated, their system can be integrated with the accredited bank's system for seamless data-interface relating to expenditure advisory, as well as for automated reconciliation.

Appendix - A

Banking Arrangement in Districts Without Internet Connectivity

There may be a small number of district RCH Societies who may not have Internet connectivity with the accredited bank due to the topographical terrain or otherwise.[6] The proposed business process for these SCOVAs is given below.

Alternative-1:

The district RCH Societies, which are not able to connect through net log-in facility may have to go through the following procedure:

- They will have a bank account in the accredited bank's branch in the state capital and the branch will issue cheque-books (payable at the state capital) to the district RCH Societies.
- The state SCOVA will send an item-wise budget on paper to the district RCH Society.
- The district RCH Society will issue cheques to parties/agencies in the normal way.
- The bank will have the following format printed on the reverse of the cheques:

PARTY / AGENCY **ADVANCE**

- **Item of Expenditure :**
- **Sanction No. of GoI :** **Date :**
- **Sanction No. of State :** **Date :**
- **Name and Addressof the Party / Agency :**
- **UC Due Date :**

[6] It is expected that we will not face any Internet connectivity problem in any of the districts. Multiple Internet Service Providers (ISPs) like NIC, Reliance or Spectranet are expected to be present in each of the districts. However, as a contingency plan, the business process given here is to build redundancy into the proposed system.

When the cheque reaches the branch of the accredited bank in the state capital after clearing, the bank will make the data entry in the SoE Table pertaining to the district RCH Society's bank account.

Date entry pertaining to settlement of advances will be done by the state SCOVA on behalf of the district RCH Society in the SoE Table of the district RCH Society's account in the accredited bank, when the account is submitted by the district RCH Society in the normal course.

Alternative-2

- An account will be opened in the name of the district RCH Society in the branch of the accredited bank in which the state SCOVA has an account at the state capital.
- The state SCOVA will transfer the fund through account transfer to the district RCH Society's account in the same branch at the state capital when allocating funds to the district RCH Society.
- The district RCH Societies not having net log-in facility with the accredited bank, will be allowed to keep another account with the bank they are banking with now at their location.
- Operating the district RCH Society's account in the accredited bank at the state capital, the state SCOVA will transfer the money to the district RCH society's bank account (at district) through EFT or will send a draft. No withdrawal right will be given to the state SCOVA from this account.
- The district RCH Society will do its banking transaction as at present.
- They will compile the account as at present and send them to the state SCOVA monthly.
- The state SCOVA will update the SoE Tables, item of expenditure-wise, in the account of the district RCH Society kept in the accredited bank at the state capital through net-log-in. **Alternatively, an outsourced person from the accredited bank will visit the district society's office weekly and collect the MIS and upload it to the central web server of the bank.**
- Thus, all the concerned entities will have the MIS related to these district RCH societies monthly.

Note:

Alternative -2 has some advantages over Alternative-1:

- Under Alternative-2 only those SCOVAs will be allowed to operate through this route, which do not have Internet access to the accredited bank.
- Counting on the fact that 100 percent of SCOVAs are expected to be doing Internet banking, Alternative-2 may be accepted as a contingency mechanism.
- Needless to say, the bank will send monthly accounts details/scrolls in the prescribed format both to the district and state SCOVAs for reconciliation purposes.

Introduction

This document is **Document 2** of the Reproductive and Child Health Phase II Program. It summarizes the principles, evidence and rationale that underpin the strategic direction and priorities of RCH Phase II, in which context the states will be designing their PIPs and log frames. It draws on the experience of RCH Phase I, the global and Indian evidence base, and established international best practice.

RCH PHASE II PROGRAM - DOCUMENT 2

1

Improving Health Outcomes

1.1 Population Stabilization

1.1.1 Policy evolution

In 1951, India became the first country in the world to launch a family planning program. Since then approaches to reducing population growth have taken a variety of forms. The passive, clinic-based approach of the 1950s, gave way to a more proactive, extension approach in the early 1960s. The late 1960s saw the emergence of a "time-bound", "target-oriented" approach with a massive effort made to promote the use of IUDs and condoms. This was followed by a "camp approach" in the 1970s. The 1980s saw the rebuilding of the program with an emphasis on female sterilization, and maternal and child health. In the 1990s the International Conference on Population and Development, Cairo prompted a paradigm shift, with the advocacy of a client-centered, quality-oriented, reproductive health approach. Method-specific targets were removed, and the program focused on the unmet needs of clients, and RCH Phase II continues with this approach. The National Population Policy of 2000 while legitimizing the new approach also sets 2010 as the target date to achieve replacement-level fertility.

1.1.2 Regional variation

National progress must be seen in the context of striking regional differences. The five Empowered Action Group (EAG) states of Bihar, Madhya Pradesh, Orissa, Rajasthan and Uttar Pradesh, together with the three new states formed in this region, Jharkhand, Chattisgarh and Uttaranchal had an estimated combined TFR of 4.2 in 2000. For this region as a whole it would take at least another 26 years to reach replacement fertility under the current rate of decline (Table 1.1). Thus, without acceleration of fertility decline in EAG states, India cannot hope to achieve replacement fertility by 2010. Assuming the prevalence of below-replacement fertility in some southern states, India at best could hope to achieve a TFR of 2.6 by 2010.

Table 1.1. TFR and Projected Number of Years to Reach Replacement-level Fertility

State	TFR 2000	Mean fall during last 10 years	Years required to achieve TFR of 2.1	Expected TFR in 2010
Andhra Pradesh	2.5	0.81	4	1.8
Assam	3.2	0.61	18	2.6
Bihar*	4.3	1.08	20	3.2
Gujarat	3.0	0.41	22	2.6
Haryana	3.3	0.86	14	2.4
Himachal Pradesh	2.4	1.35	2	1.8
Karnataka	2.4	1.03	3	1.8
Kerala	1.9	0.17	0	1.8
Madhya Pradesh*	3.9	0.86	20	3.0
Maharashtra	2.7	0.79	7	1.9
Orissa*	2.9	0.89	9	2.0
Punjab	2.6	0.82	6	1.8
Rajasthan*	4.1	0.45	45	3.7
Tamil Nadu	2.0	0.49	0	1.8
Uttar Pradesh*	4.6	0.75	34	3.9
West Bengal	2.4	1.02	3	1.8
ALL INDIA	**3.3**	**0.74**	**16** (18)**	**2.5** (2.6)**
Mean for EAG	4.2	0.82	26	3.4

*EAG States **State-weighted average Source: Professor Mari Bhatt (IEG)

Table 1.2 shows the position of EAG states with respect to some important determinants of fertility around the year 2000, average changes in the determinants during the last 10 years, and the number of years it may take for the region as a whole, to reach the levels required to attain a TFR of 2.1. Indicators in some southern states have been taken as the norm for required levels to reach replacement-level fertility.

Table 1.2: Determinants of fertility in EAG States and Projected Number of Years to Reach Replacement-level Fertility

Indicators	Level 2000	Change over last decade	Required level for TFR of 2.1	Required number of years
Percent using contraception	34	10	65	31
Median age at marriage	15	0.5	18	60
Unmet need for contraception	21	5	5	32
Ideal family size	3	0.3	2	33
Female literacy rate, age 7+	45	15	80	23
Infant mortality rate	85	28	40	16
Empowerment of women	Low	NA	High	NA
Exposure to mass media	41	12	75	28
Home visit by ANM (%)	5	NA	20	NA

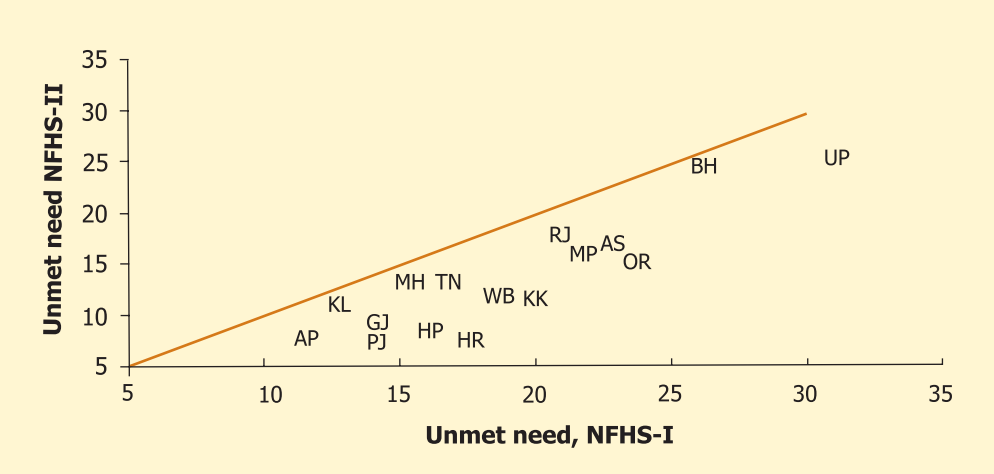
Source: Professor Mari Bhatt (IEG)

It has been estimated that with current trends, it will take the EAG states at least 26 years for the "use of contraception", "female age at marriage", "unmet need for contraception", "ideal family size" and "regular exposure to mass media" to reach their respective levels required to attain replacement-level fertility. Only trends in "infant mortality" and "female literacy" suggest that they would be reaching the required levels earlier. Yet, an important caveat with respect to their trends must be noted - although the average decline in IMR during the last 10-years has been quite rapid, there has been a substantial deceleration in the rate of decline in recent years, and further decline could be more difficult than the linear projection suggests.

1.1.3 Unmet need for contraception

The NPP document and the recent report of the Steering Committee on Family Welfare for the Tenth Five Year Plan lays great emphasis on addressing the unmet need for contraception, in order to achieve population stabilization. High levels of unmet need for contraception in EAG states are well documented by NFHS-I and II (Figure 1) and district RCH surveys.

Figure 1.1 Unmet need for contraception (%) in major states, NFHS-I & II



However, it is unlikely that inadequate access to services is the main or even a major reason for the unmet need for contraception. A carefully conducted investigation in the Philippines shows that unmet need for contraception arises from several reasons, such as weak motivation, low female autonomy, perceived health risks, and moral objection to the use of contraception. The elimination of these factors could be as challenging as generating a fresh demand for contraception. The estimated number of couples with an unmet need for contraception is provided in Table 1.3.

1.1.4 Current choice of contraception

On a nationwide basis the family planning program currently offers five modern contraceptive options. The methods currently available for spacing are - oral contraceptive pills, condoms and intra-uterine devices. Male and female sterilization is often used for limiting family size.

Table 1.3: Estimated Number of Couples with Unmet Need for Contraception, 1998/2003

Major States	Unmet need for contraception NFHS-II, 1998-97			Eligible couples 31 March, 1998 ('00s)	Number of unmet need couples in 1998/2003		
	Spacing	Limiting	Total		Spacing	Limiting	Total
Andhra Pradesh	5.2	2.5	7.7	137876	7170	3447	10616
Assam	7	10	17	38885	2722	3889	6610
Bihar*	12.6	11.9	24.5	171605	21622	20421	42043
Gujarat	4.8	3.7	8.5	81862	3929	3029	6958
Haryana	2.9	4.7	7.6	32555	944	1530	2474
Karnataka	8.3	3.2	11.5	85723	7115	2743	9858
Kerala	6.9	4.9	11.7	51590	3560	2528	6036
Madhya Pradesh*	8.9	7.3	16.2	136767	12172	9984	22156
Maharashtra	8.1	4.9	13	153387	12424	7516	19940
Orissa	8.7	6.8	15.5	58690	5106	3991	9097
Punjab	2.8	4.5	7.3	36740	1029	1653	2682
Rajasthan	8.7	8.9	17.6	92146	8017	8201	16218
Tamil Nadu	6.6	6.4	13	105506	6963	6752	13716
Uttar Pradesh*	11.8	13.4	25.1	274389	32378	36768	68872
West Bengal	6.3	5.5	11.8	129748	8174	7136	15310
ALL INDIA	**8.3**	**7.5**	**15.8**	**1658687**	**137671**	**124402**	**262073**
EAG states	10.9	11	21.9	733597	79295	79365	158386

* Including newly formed states of Jharkhand, Chattisgarh and Uttaranchal

Source: Professor Mari Bhatt (IEG)

1.1.4.1 Oral contraceptive pills

There are two types of oral contraceptive pills - combined oral contraceptives (COCs), also known as the "The Pill", and the progestogen-only pills (POPs) also known as the "mini pill". At present only the combined pill is available in India. When used correctly, COCs have a pregnancy rate of 1-8% in the first year of use. Whilst there may be some side effects such as nausea, breast tenderness, breakthrough bleeding and headache, COCs offer a range of therapeutic advantages such as the regulation of menstrual cycles, decreased menstrual flow, some protection against ovarian and endometrial cancer, benign breast diseases and the prevention of ectopic pregnancies. Limitations of COCs include the need for strict user compliance and the fact that effectiveness may be lowered when certain concurrent medication is taken. Serious side effects (thrombosis), though rare, are possible. In India 2% of currently married women use COCs (NFHS-II 98-99).

1.1.4.2 Condoms

Condoms are effective immediately, have no method-related health risks and are the most popular barrier contraceptive in India. They have the advantage of being the only contraceptive method that provides dual protection from pregnancy as well as from STI and HIV. When used correctly, the failure rate is 3% in the first year of use (but when account is taken of how condoms are more commonly used, this rate is estimated to be 14%). The NFHS-II (1998-1999) shows that 3% of couples use condoms as a method of contraception.

1.1.4.3 Intrauterine Devices (IUDs)

IUDs are made from plastic and may contain copper or a progestogen. They are the most effective long term, reversible method of contraception. The first year pregnancy rate for the Copper T 200B (effective life three years) is 0.5 – 3% and the equivalent rate for the Copper T 380 (effective life 10 years) is 0.6 – 0.8%. They are suitable for women who are breast-feeding, are not user dependent, inexpensive and do not interfere with intercourse. IUD use does, however, require a trained provider for counseling and insertion. IUDs may increase the risk of PID in users with a history of RTI/STIs and those with multiple partners. Increased menstrual flow and cramping are common, usually settling within the first few months. NFHS-II estimates that 2% of currently married women use IUDs.

1.1.4.4 Female sterilization

Tubal ligation provides permanent contraception for women. It is a safe, simple surgical procedure relatively free of side effects, can be performed on an outpatient basis under local anesthesia. It requires little surgical time, causes minimal discomfort to the client who can be discharged two to four hours after surgery. The two most common methods are laparoscopy and mini-laparotomy. Laparoscopy requires expensive equipment and well-trained surgeons or Obstetric/ Gynecology specialists. Counseling to ensure informed consent is of particular importance in sterilization programs, because the method is intended to be permanent. Tubal ligation is more effective than COCs, IUDs or injectables. The failure rate in the first year for mini-laparotomy is 0.4 – 1% and for laparoscopy is 0.1 –0.5%. Tubal ligation is the most popular and widely promoted method of contraception in India. According to NFHS-II (1998-99), 34% of currently married women in India have accepted female sterilization.

1.1.4.5 Male sterilization (Vasectomy)

Vasectomy is a highly effective, safe and permanent method of sterilization for men. Men are still able to produce semen and have the same sexual feelings, desire and capabilities after a vasectomy. Vasectomy does not cause impotence, weakness or affect the man's ability to work and support the family. There are two procedures for doing vasectomy: "conventional vasectomy" and "no scalpel vasectomy (NSV). The conventional vasectomy procedure involves making either one or two small incisions in the scrotum and requires blunt and sharp surgical dissection and there is a risk of hematoma. No-scalpel vasectomy is a modified, sophisticated technique that requires no incision, only a small puncture and therefore no stitches. It is a safe, simple procedure that can be performed in a low-tech, low-resource setting. The failure rate is usually 0.2 – 1 % in the first year. The current acceptance of the method in the country is 2%.

1.1.4.6 Emergency contraception (EC)

Pregnancy may result following unprotected sexual intercourse, rape or a contraceptive failure. EC is a means to prevent pregnancy in such situations. It is meant as a one-time protection for women who

suspect they may be at risk of getting pregnant. Women seeking emergency contraception should be offered the immediate choice of an acceptable ongoing method of contraception. There are two types of EC, the progestin only pill and the IUD. The progestin only pill (75mg) can prevent pregnancy within 72 hours after unprotected intercourse. It reduces the risk of pregnancy by 89 % (from about 8% to 1%) when used correctly. In the first 24 hours after a single act of unprotected intercourse, it can prevent 95% of expected pregnancies. Side effects associated with this type of EC are nausea, vomiting and menstrual irregularities. IUDs can be effective as EC. An IUD must be inserted within five days of unprotected intercourse. Very few pregnancies have ever been reported; the failure rate is less than 0.1%.

1.1.5 Expanding contraceptive choices in RCH Phase II

International evidence shows that increasing the availability of method choice increases acceptance rates. It is estimated that every additional method increases the contraceptive prevalence rate by 12%. A wider contraceptive choice, including natural methods, helps meet the changing needs of couples during their lives. Multiple methods make switching easier, reduce method-specific discontinuation, and improve user satisfaction. Contraceptive choice can be expanded both by adding new methods to the existing range as well as increasing access to the services providing the choice. There are several possible additions that would improve the range of choice offered by the RCH Phase II program:

1.1.5.1 Injectable contraceptives

Two types of injectable contraceptives are available - progestin only injectables and combined injectables. They are not in the National Family Welfare Program presently. Studies on injectable contraceptives are ongoing at present.

1.1.5.2 The Lactational Amenorrhea Method (LAM)

LAM is based upon the natural infertility experienced by breastfeeding women, especially during the early postpartum months. LAM is now being promoted as a contraceptive choice to women. LAM is approximately 98% effective as long as *all* the following conditions are met:

- The mother is less than six months postpartum.
- The woman's menses have not returned.
- The mother is "fully or nearly fully" breastfeeding her baby (whenever the baby cries, at least six times a day including night feeds, the baby is being fed exclusively from the breast and intervals between feeding are less than four hours during the day and six hours at night)

Under these conditions, LAM can be highly effective, with no physical side effects and brings crucial benefits to the neonate. The main limitation is that although it costs the health services next to nothing, there are significant opportunity costs for the mother and it offers no protection against STIs/HIV.

1.1.5.3 Standard Days Method (SDM)

The Standard Days Method (SDM) is a simple method based on fertility awareness; the woman learns how to tell when the fertile time of her menstrual cycle starts and ends. It is based on WHO data that women who usually have a 26 to 32 day cycle are potentially fertile from day 8 to day 19. SDM allows the woman to identify the days in each cycle when she is least likely to become pregnant if she has unprotected intercourse. There are innovative aids to assist women to keep track of their menstrual cycle such as CycleBeads™. This method is natural and has no side effects. It is effective and relatively

easy to teach, learn and use in a low resource setting. Limitations include the high degree of motivation that the couple must have, it is also difficult for women with irregular menstrual cycles, needs the man's involvement and cooperation and it does not provide protection from STI/HIV.

1.1.5.4 Centchroman

This is a new form of oral contraceptive pill that does not contain any steroidal hormones, developed by the Central Drug Research Laboratory, Lucknow. It appears to be safe and economical and is sold under the brand names **"**Saheli" and "Centron". It is taken once a week and is very convenient. It is very effective and can increase client privacy. There are no known side effects, except that in about 8% of users there is a delay in menses. Fertility typically returns within six months of discontinuation of Centchroman. It is not suitable for women with active or recent liver disease, ovarian disease or chronic cervicitis and it does not provide protection from STI/HIV.

1.1.5.5 Female condoms

These are safe, pre-lubricated barrier contraceptives. When worn, it lines the vagina gently. It should be used only once and then discarded. It offers protection against both pregnancy and STI/HIV. It requires considerable motivation from the woman.

1.1.6 Strategies to expand contraceptive choice in RCH Phase II

Human resource capacity must be developed to deliver quality family planning services. This will include training and also strengthening the management of public institutions.

1.1.6.1 Expanding the range of FP services

To increase access to services and address unmet needs, the pool of public sector providers will be increased to deliver quality services. The current number of trained providers for sterilization services is insufficient. Each CHC and PHC having an OT (operation theatre) facility will have at least one MO (Medical Officer) trained in one method of sterilization. All the CHCs/PHCs will have at least one MO posted who can be trained for abdominal tubectomy. This method does not require a postgraduate degree or expensive equipment. Similarly, MOs will be trained for no scalpel vasectomy (NSV). Specialists from district hospitals and CHCs will be trained in laparoscopic tubal ligation.

Operational strategy

- Training centers will be established in medical colleges and district women's hospitals (DWH) for training in female sterilization and spacing methods. These centers will create master trainers in the respective methods through a ten-day Training of Trainers (ToT) course. The master trainers will then conduct induction training for the surgical teams from the districts, comprising doctors and nurse assistants. This induction training is for 12 working days for doctors and 6 working days for nurses. The master trainers will also train district trainers to monitor, support and supervise the fresh inductees in each district.
- To train trainers in NSV, experienced providers will undergo a ToT of three days' duration. They will in turn train medical officers in an induction training of five days. There will be a follow up of all trained providers at the end of one month following the training, to assess their proficiency.
- A systemic effort will be made to assess the needs of all facilities, including:
  - Inventory of staff in position and their training needs
  - The availability of electricity and water

- Operation theatre facilities for district hospitals/CHCs/PHCs
- Inventory of equipment, consumables and waste disposal facilities
- The condition, location and ownership of the building.

At least three functional laparoscopes will be made available per team for doing laparoscopic sterilization, as will the equipment and training necessary to provide IUD and emergency contraception services. Each health facility will be assessed as per the list above. Vacant positions will be filled on a contractual basis. The sub-center rent may be increased and alternate strategies for constructing village sub-centers with community participation will be piloted, to see if this facilitates ANMs residing in the sub-centers.

Outcome: An increase in the number of acceptors of male sterilization, female sterilization, IUD and emergency contraception services in line with recommended quality standards.

1.1.6.2 Improving and integrating RCH services in PHCs and sub-centers

The capacity of Lady Health Visitors (LHVs) and Auxiliary Nurse Midwives (ANMs) will be built through skill-based clinical training for spacing methods including IUCD insertion and removal, lactational amenorrhea method (LAM), standard days method (SDM) and emergency contraception (EC). They will also be trained in infection prevention, counseling and follow-up for different family planning methods. MIS training will also be given to the health workers to enable them to collect and use the data accurately. Their supervisors will be trained for facilitative supervision and MIS. This will help to develop improved supervisory skills and an increased ability to interpret and analyze data for adequate feedback and monitoring.

Operational strategy

- Training centers will be established as in 1.1.6.1. The master trainers will train lead trainers/ANM tutors from ANM training centers, LMOs from the district women's hospital and doctors and PHN instructors from the Regional Health and Family Planning Training Centers (RFPTC).
- The team of lead trainers/ANM tutors and RFPTC trainers will conduct a follow-up of trained LHVs and ANMs after one month and six months of the training and provide supportive feedback to the service providers and medical officers in-charge (MOIC) of the PHCs.
- Facilitative supervision of each ANM will be conducted on a regular basis at least once a month by LHVs and feedback provided to the ANM and MOIC.

Outcome: An increase in the number of acceptors of an expanded range of methods.

1.1.6.3 Training of District Hospital/CHC/PHC staff to offer an expanded choice of services

Training providers to offer LAM, SDM, EC and injectables will help to increase the range of choice and ensure quality services and follow-up for clients.

Operational strategy

- A one-day ToT for the master trainers of the district hospitals and half-day training for all the doctors in the district, for technical update including follow-up and quality of care issues regarding injectables.

- The overall strategy for increasing delivery of services is to ensure family planning service availability throughout the year at district hospitals, at the CHC/FRU for at least six months in a year and at least once every month at the PHCs.
- Training ANMs to provide family planning services.

Outcome: More access to a wider range of methods from PHCs, CHC/FRUs and district hospitals

1.1.6.4 Forging linkages with the ICDS division of women and child development department

The ICDS program provides nutritional and health services through a network of Anganwadi centers. The Anganwadi worker (AWW) is involved significantly in catering to the health needs of mothers. Given the extensive network of the Anganwadi centers and the fact that the AWWs have a very good rapport with the community and are already providing a few family welfare services, they will be trained and be actively involved in counseling clients, provision of spacing methods including oral pills, condoms, LAM and SDM and community mobilization. Convergence of services at the grassroots would ensure increasing the access to and demand for services.

Operational strategy

- A detailed action plan will be produced in coordination with the ICDS department for involvement of the AWWs and their role in increasing access to contraceptive services.
- The Department of Health officials and ICDS officers will be orientated regarding the plan.
- AWWs and their supervisors will receive technical training and training in communication skills and record keeping by the MO of the PHC and LHV.

Outcome: More people access family planning services from AWWs.

1.1.7 Engaging the private sector to provide quality family planning services

The private sector is the major provider of curative health services in the country. Engaging the private sector to provide family planning services has the potential to significantly expand the coverage of quality services. Public-private partnerships can stimulate and meet the demand for good quality healthcare services and also have a synergistic impact on the RCH Phase II. To ensure efficient services of good quality from the private and public sectors, robust monitoring and regulatory mechanisms will be developed.

1.1.7.1 Incentives and training to encourage private providers to provide sterilization services

Unless there are incentives for the private sector to venture into this area, its involvement is unlikely. The provision of fixed payments for clients served will encourage the private clinics and doctors to provide services normally given through government health facilities. Mechanisms will be designed to ensure that the poorest can also gain access. The clinical skills of private doctors will be developed in vasectomy, abdominal tubectomy and laparoscopy. Forty-three percent of the total IUD clients obtain

their services from the private sector. Training private female doctors in IUD insertion and promoting such providers will help to expand the coverage of these services and increase the total use of IUCD.

Operational strategy

A detailed plan will be developed in consultation with the private sector for determining the amount and mode of payment, the regulation and monitoring frameworks necessary and safeguards to ensure equity of access. Training for the private sector will be provided as above and approved and monitored providers will be promoted. They will also be eligible for discounted supplies.

Outcome: More people access quality, equitable family planning services from the private sector.

1.1.7.2 Encouraging the use of public facilities by private doctors on a fee-sharing basis

Private doctors will be allowed to use public facilities on a fee-sharing basis, for example in the evening when CHC/PHCs are normally closed. This will optimize the utilization of the public health facilities' existing infrastructure and make services more accessible, especially to day laborers.

Operational strategy

Local private doctors will be identified and invited to participate in consultative meetings and assist in drawing up a partnership action plan.

Outcome: More people access quality and equitable family planning services from private providers in public facilities.

1.1.7.3 Regulation and accreditation of public and private sector facilities

This will be an essential step in improving the quality and coverage of services provided by both the private and public sector. The private sector is unlikely to agree to regulation if it does not also apply to the public sector. Although the relation must be managed carefully, the private sector has the potential to become an important stimulus for public sector quality improvement.

Operational strategy

A mechanism for regulation and agreed standards will be developed in consultation with the stakeholders. The GoI has laid down criteria for establishing quality assurance committees at the state and district levels for monitoring the family planning program, especially in relation to sterilization services. In addition, guidelines and standards for various contraceptives are also laid down. These would be revised in tune with the latest updates on contraceptives and quality care. Stricter quality care monitoring would be undertaken through these measures.

Outcome: More people will have access to high quality, regulated services from both the public and private sectors.

1.1.7.4 Providing safety insurance cover

Private sector providers may be reluctant to collaborate due to the fear of criticism and litigation. Insurance schemes to indemnify private providers will serve as an incentive to provide family planning services with the government.

Operational strategy

Insurance schemes for private providers will be designed and implemented.

Outcome: More people will access quality family planning services from the private sector.

1.1.8 Stimulating demand for quality family planning services

1.1.8.1 Increasing compensation

Compensation payments have been increased in the EAG states vide Government Order M 12013/2/2003-EAG dated 9/3/04, which makes the following provisions:

Operational strategy

- In public facilities, compensation for a tubectomy is to be raised from Rs.300 to Rs.400 and from Rs.200 to Rs.400 for a vasectomy.
- A minimum cash reward of Rs.200 will be paid to the acceptor of a tubectomy and Rs.250 to the acceptors of vasectomy (the difference can be retained at the facilities for improving quality).
- Accredited private providers providing services for BPL families, without charging user fees, will receive Rs.400 per sterilization and Rs.75 per IUD. Private providers are entitled to charge non-BPL clients a user fee.
- Private providers providing sterilization in public health facilities will be paid a compensation of Rs.100 per case, subject to a minimum of Rs.1000/day.
- In case of failure of permanent methods the acceptor will be eligible for safe medical termination of pregnancy and compensation of Rs.5000.

Outcome: More people access quality family planning services from the public and private sectors.

1.1.8.2 Using the media

NFHS data shows that exposure to family planning messages through mass media has a strong and independent effect on the current demand and future intention for contraception services among non-users. Recent research suggests this may be through stimulating discussions between spouses, friends, neighbors, workmates and health workers. Keeping that in mind, these messages need to be focused.

Operational strategy

Promote the following three inter-linked areas, recommended for the RCH Phase II - BCC strategy, to reduce TFR through the mass media.

- Birth spacing
- Delaying the age of marriage
- Reducing gender bias

Outcome: More people access (or plan to access in the future) quality family planning services from the public and private sectors.

1.1.8.3 Involving satisfied users

Satisfied users can be important promoters of the services.

Operational strategy

Recruiting such couples to work in collaboration with grassroots health workers may assist in stimulating the demand for services.

Outcome: More people access (or plan to access in the future) quality family planning services from the public and private sectors.

1.1.8.4 Increasing the gender awareness of providers and increasing male involvement

Women worldwide seldom take major decisions within the family. This is especially true in India. Therefore, empowering women and increasing male involvement in family planning becomes essential to ensure that women are truly equal partners in choices regarding fertility control and childbirth.

Increasing male involvement in the RCH Phase II will not only focus on the increased use of male methods, but will also aim to encourage men to support women's contraceptive choices and use. Male methods account for only 6% of current contraceptive use. Vasectomy and NSV are safer and easier to perform in primary health centers than tubectomy. Vigorous efforts should be made to promote this method. As males are the main decision makers in Indian households, BCC activities also need to focus on men.

Operational strategy

Gender sensitization training will be provided for all health providers in the CHC/PHC and integrated into all other training activities. The RCH Phase II program seeks to support attitudinal change at all levels of health providers in favor of gender equality, so that they have a greater awareness of the factors that influence women's decision-making and thereby help them respond better to the needs of women and support her in exercising her choice. Demand for male contraceptives, men's reproductive health services and male involvement in RH care of women will be stimulated through designing and implementing male-focused BCC activities. Service delivery sites for male methods will be expanded, by training health providers in NSV and conventional vasectomy, so that each CHC and Block PHC in the district has at least one provider trained in NSV.

Outcome: Improved gender awareness among providers leads to more people accessing family planning services, and more men become involved both as FP acceptors and supporters of their partner's decisions.

1.1.8.5 Social marketing

Despite a longstanding social marketing program for condoms and pills, there has been no marked increase in the use of these methods. The experience of neighboring countries suggests substantial potential for greater use of pills by younger couples, if supported by counseling and BCC activities. The social marketing program has suffered from the following setbacks.

- A strong urban bias in the distribution network
- Low incentives for commercial participants
- A limited range of products
- The simultaneous presence of a wasteful, free distribution system.

Operational strategy

Social marketing of contraceptives, especially in rural areas will be strengthened. A strategy for social marketing is being developed and will include the marketing of products and improving services through social franchising. The creation of service availability through social franchising would enhance the availability in rural areas. The range of methods will be broadened. Community based depot holders and distributors will be a part of the social marketing strategy. Social franchising would be the method to franchise the services by franchising healthcare of an acceptable quality, at affordable prices to the community. Condom vending machines are being introduced on a pilot basis in 54 HIV high-prevalence districts. National AIDS Control Organization (NACO) and Department of Family Welfare have jointly promoted the project on a cost-sharing basis.

Outcome: More people will access a broader range of socially marketed methods.

1.1.9 Involving Panchayati Raj Institutions, Urban Local Bodies and NGOs

1.1.9.1 Establishing depot holders to increase coverage of family planning services

Many women are unable to leave their homes to access health facilities. This is a major barrier even in life-threatening situations. Involving PRIs (Panchayati Raj Institutions), ULBs (Urban Local Bodies) and NGOs to mobilize the community, sensitizing community members to gender issues and training community members will enable women to access contraceptive services closer to home and support them in increasing their mobility.

Operational strategy

One couple from each village will be selected by the villagers themselves and will be trained to provide counseling and services for non-clinical FP methods such as pills, condoms, LAM and SDM. They will be supplied with pills and condoms by the ANMs, for free distribution, and act as depot holders for these supplies. They will also procure pills and condoms from social marketing agencies and provide these contraceptives at a subsidized rate. They will provide referral services for methods available at the medical facilities. They will assist in community mobilization and sensitization.

Outcome: More people will access family planning services from depot holders of pills and condoms and be appropriately referred.

1.1.9.2 Building partnerships with NGOs

NGOs have the flexibility to create an enabling environment for increasing acceptance of contraceptive services in the community. New models will be developed for reaching out to younger men, women, newly married couples and resistant communities. These will be scaled up as appropriate.

Operational strategy

- Identify suitable NGOs against agreed criteria
- Provide financial, technical and managerial support for implementation
- Monitor, evaluate and assess potential for scaling up.

Outcome: More people access family planning services through NGOs.

1.1.9.3 Building new partnerships for expanding contraceptive use

Involving District Urban Development Authorities (DUDAs) and Cooperative Societies will complement the efforts of the public and private sectors in contraceptive service delivery, increasing availability of, and access to, quality services. These agencies will help in stimulating the demand for family planning services.

Operational strategy

Agencies who are willing to be partners will be identified. Using their networks, family planning messages, information and motivation to seek services and referral services, will be planned.

Outcome: "Community Health Worker Couples" will be identified by NGOs to provide non-clinical FP services and manage a depot of free and socially marketed pills and condoms in at least one village in each PHC area.

1.1.9.4 Involvement of industrial groups

In order to broaden the network of contraceptive service delivery, industrial workplaces will be encouraged to provide reproductive health information and services to the community as part of their social responsibility.

Operational strategy

Identifying and training industrial workers to act as counselors and depot holders for providing condoms and pills to fellow workers during free time/lunch hour and also to act as peer educators.

Outcome: More people will access counseling, pills and condoms through the workplace.

1.1.10 Contraceptive requirements

The demand for contraceptives will rise if the above strategies are successful. As per the goals of the Tenth Plan, by 2007 permanent method use should be 50%, and reversible method use should be 15%, compared with the present 35.5% and 8% respectively (NFHS-II and RHS 1998-1999). To achieve these targets, the required increase in the annual acceptance rates of various methods of contraception has been worked out. To do this, it was found necessary to correct the official estimates of acceptance rates for the base period (1997-2002). NFHS-II and RHS have shown that the percentage of sterilized women is 20% higher than what was suggested by the official estimates, whereas IUD and pill users are one-fourth and condom users are two-thirds of the corresponding official figures.

A revised figure for "equivalent sterilizations" was arrived at by raising the sterilizations by 20%, but dividing the number of IUDs by 12, pill users by 36 and condom users by 27. The corrected annual rate at the state level for 1997-2002 showed a strong correlation with the survey-based estimates of modern method use (r=0.83), and suggested that for the modern method use to reach 65% by 2007, the annual equivalent sterilization rate would need to increase by 60% from the average annual rate for 1997-2002. As the population in the reproductive ages is also projected to increase by 19%, the annual number of equivalent sterilizations should nearly double. To achieve the anticipated change in the method mix, the number of sterilizations should increase annually by 8.6% and acceptance of reversible methods must rise annually by 11%.

1.1.11 Studies and operational research

Operational research and development in RCH is important not only in modern medicine, but also in the traditional, ayurvedic and unani systems. DoH&FW will continue to commission and fund research and

development through the ICMR. DoH&FW will continue to entertain proposals in the form of projects from other research institutions in areas relevant to RCH. Important areas for operational research will include:

- Male involvement and issues affecting male behavior and attitude
- Behavioral and operational barriers to women accessing contraceptive services
- Understand how effective linkages can be built with the different cadres of field workers from different departments in an efficient manner
- Mechanisms to involve women in planning/monitoring health services
- Identification and dissemination of best practices in the area of contraceptive services.

1.2 Maternal Health

The National Population Policy Goals

- Reduce maternal mortality rate to less than 100 per 100,000 live births by the year 2010 [Current level: 407 (SRS 1998)].
- Increase proportion of institutional deliveries to at least 80% by 2010 [Current level 39.8% (RHS 2002-03)]

1.2.1 The burden of maternal mortality in India

Maternal death is defined as death of women while pregnant or within 42 days of the termination of pregnancy from any cause related to or aggravated by pregnancy or its management (see references). The Maternal Mortality Rate (MMR) is the number of maternal deaths per 100,000 live births in one year. WHO estimates show that out of the 529,000 maternal deaths that occur globally each year, 136,000 (25.7%) are from India. This is the highest burden for any single country in the world.

The estimates of MMR in India in recent years are shown in Table 1.4.

Table 1.4: Recent Estimates of MMR in India

Sample Registration System Survey	356 (1993)	407 (1998)
National Family Health Survey	424 (1992-93) Rural 448 / Urban 397	540 (1998-99) Rural 619 / Urban 267

The state-wise estimates of MMR from the SRS data (1998) are shown in Table 1.5.

The causes of maternal deaths estimated by the Registrar General of India in 1998 are shown in Figure 1.2. Hemorrhage, sepsis, obstructed labor and unsafe abortions are the major causes of maternal mortality. Anemia among pregnant women contributes to about one-fifth of all maternal deaths.

1.2.2 Maternal care indicators

In India, in 1998-99, only 42.3% deliveries were conducted by skilled attendants (Table 1.6). There has been an increase of 8% in this rate in the preceding five years. It is noteworthy that 50% of this increased coverage is due to the doctors. TBAs continue to conduct over one third of all deliveries. As

Table 1. 5 State-wise MMR (SRS 1998)

States	MMR
Punjab	199
Haryana	103
Uttar Pradesh	707
Bihar	452
Rajasthan	670
Madhya Pradesh	498
Orissa	367
Assam	409
West Bengal	266
Maharashtra	135
Gujarat	28
Andhra Pradesh	159
Karnataka	195
Tamil Nadu	79
Kerala	198
INDIA	**407**

expected, the proportion of deliveries being managed by skilled attendants is low in rural areas (33.5%), among the poor population (25.4%) and among illiterate women (25.4%) (NFHS II).

In 1998-99, only 33.6% of births occurred in health facilities/institutions (NFHS II), an increase from 25.5% estimated in NFHS I (1992-1993) and was essentially due to the increase in the deliveries in

Figure 1.2. Causes of Maternal Deaths (SRS 1998)

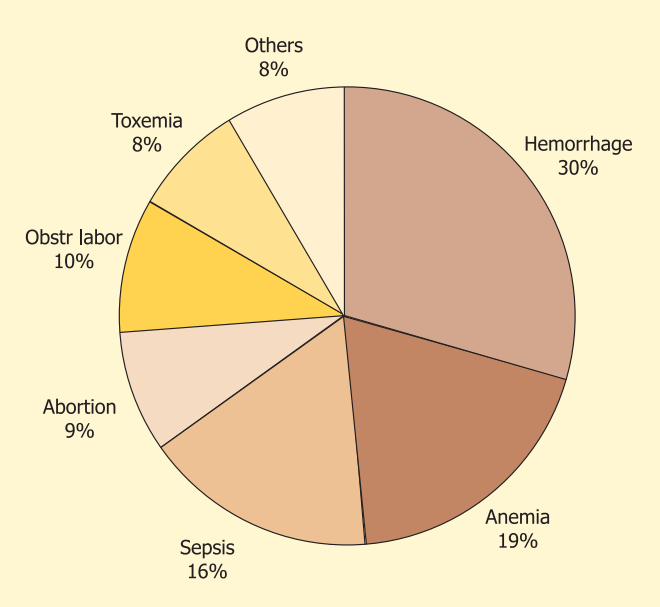


Table 1.6. Trends in Place of and Assistance During Delivery
(All values are in percentages)

	1992-93 (NFHS I)	1998-99 (NFHS II)
Place		
Home	**73.5**	**65.4**
Health facility/Institution	**25.5**	**33.6**
Public	14.6	16.2
Private	10.9	16.7
NGO	-	0.7
Other missing	**0.5**	**1.0**
Assistance		
Traditional birth attendant	**35.2**	**35.0**
Skilled attendant	**34.2**	**42.3**
Doctor	21.6	30.3
ANM/Nurse/Midwife/LHV	12.6	11.4
Other health professionals	-	0.6
Other	**29.5**	**22.4**
No information	**1.1**	**0.3**

private institutions from 10.9% to 16.7%. In 1998-99 (NFHS II) almost 75% deliveries in rural areas continued to occur in the home settings and over 80% of births among illiterate women or those with a low standard of living index took place at home.

There are vast variations in institutional deliveries in different states. The states of Kerala, Tamil Nadu and Goa have high institutional delivery rates of 93%, 79% and 91%, while the rate is less than 25% in the states of Uttar Pradesh, Madhya Pradesh and Bihar (Table 1.7).

1.2.3 Maternal health strategies in RCH Phase I

1.2.3.1 Essential obstetric care package

The essential obstetric care package in RCH Phase I consisted of the following interventions.

- Early registration of pregnancy (within 12-16 weeks).
- Provision of a minimum of three antenatal check-ups by the ANM or medical officers to monitor the progress of pregnancy and to detect any complications, so that appropriate care including referral could be given on time. Counseling on nutrition and provision of iron and folic acid supplementation for both prophylaxis and treatment of anemia are part of the antenatal check up.
- Promotion of institutional delivery and provision of facilities for safe delivery at home.
- Provision of postnatal care to monitor the postnatal recovery of the women and to detect complications early, followed by appropriate referral.

1.2.3.2 Emergency Obstetric Care

Under the earlier CSSM program, 1724 facilities (CHCs/sub district hospitals) had been identified for upgradation to FRUs. Under the RCH project, it was planned to make these fully operational for comprehensive emergency obstetric care (EmOC).

Table 1.7. Institutional Delivery Rates in Different States (NFHS II)

State	Percentage of deliveries conducted in a medical institution
INDIA	**33.6**
North	
Delhi	59.1
Haryana	22.4
Himachal Pradesh	28.9
Jammu & Kashmir	35.6
Punjab	37.5
Rajasthan	21.5
Central	
Madhya Pradesh	20.1
Uttar Pradesh	15.5
East	
Bihar	14.6
Orissa	22.6
West Bengal	40.1
Northeast	
Arunachal Pradesh	31.2
Assam	17.6
Manipur	34.5
Meghalaya	17.3
Mizoram	57.7
Nagaland	12.1
Sikkim	31.5
West	
Goa	90.8
Gujarat	46.3
Maharashtra	52.6
South	
Andhra Pradesh	49.8
Karnataka	51.1
Kerala	93.0
Tamil Nadu	79.3

1.2.3.3 Schemes for Improving Obstetric Care Services

The following schemes were introduced in RCH Phase I.

Additional ANMs - In order to improve the delivery of these services, all category C districts of the states of Uttar Pradesh, Bihar, Madhya Pradesh, Orissa, Haryana, Assam, Nagaland and Rajasthan were given support for providing additional ANMs in 30% of the sub-centers of these districts. The scheme has been extended to the remaining north-eastern states during 1999-2000. In addition, Delhi is eligible for appointing 140 ANMs for extending services to the slum areas.

Staff nurses on contract - Under the project, public health/ staff nurses have also been provided to 25% PHCs in C category districts and 50% PHCs in B category districts.

Laboratory Technicians - To build the capacity of the FRUs for looking after the needs of emergency obstetric care and RTIs/ STIs, the districts were assisted to engage two laboratory technicians on contractual basis at the sub-district level, for doing routine blood, urine examination and RTI/STI tests.

Hiring of private anesthetists - The sub-district hospitals, CHCs and FRUs are empowered to hire the services of private anesthetists for conducting emergency operations for which they will be paid Rs.1000 per case.

Hiring of safe motherhood consultants - To alleviate the shortage of trained manpower in PHCs/CHCs and sub-district hospitals, the Government of India has provided funds to the States/ UTs for engaging doctors trained in MTP techniques to visit these institutions once a week, or at least once a fortnight, on a predetermined day for performing MTPs and providing other services like antenatal check-ups. The doctors are paid at the rate of Rs. 800/- per day.

24-hour delivery services at PHCs/CHCs - To promote institutional deliveries, provision has been made under the current RCH project to give an additional honorarium to the staff to encourage round the clock delivery services at PHCs and CHCs. This is to ensure that at least one medical officer, a nurse and a cleaner are available throughout the day.

Referral transport - Under the current RCH project, provision has been made to assist women from indigent families to reach the nearest health facility by hiring locally available transport, in 25% of the sub-centers in selected states , by providing a lump sum corpus fund to Panchayats through the district family welfare offices.

TBA training - Under the CSSM Program (1992-1997) TBA training was a uniform countrywide activity. A new scheme for the training of *'Dais'* has been initiated in 2000-2001 initially in 142 districts in 15 states of the country having low safe delivery rates, i.e. below 30%.

RCH camps - In order to provide the RCH services to people living in remote areas where the existing services at the PHC level are under utilized, a scheme for holding camps has been initiated. The scheme is being implemented in 102 districts of 17 states.

1.2.4 Progress made in RCH Phase I

Assessment based on the available data and discussions with the state program managers are summarized hereunder. The recently analyzed district level household survey (Round-2) conducted in the last part of the RCH Phase I in 2002, provides additional insights. A total of 250,891 women (15-44 years) were interviewed. The salient findings are summarized in Table 1.8.

1.2.4.1 Antenatal care

According to NFHS II, only 65.4% of pregnant women received at least one antenatal check-up. Only 43.8% of women received the recommended three or more check-ups, and only one third of pregnant mothers were examined in the first trimester.

By state, there are large variations in ANC coverage. Over 90% of women received one or more check-ups in Kerala, Tamil Nadu, and Andhra Pradesh, but the figures for check ups dropped to only 36.3% in

Table 1.8. Maternal Care Indicators in Different States (District Household Survey 2002)

ANC	
No visit	26%
One visit	8%
Two visits	19%
Three visits	14%
Four or more visits	33%
Place of ANC	
Govt. institution	33%
Private institution	29%
Home	7%
Others	7%
TT	
None	20%
One	8%
Two (or more)	72%
Place of delivery	
Home	59%
Private hospital	21%
Public facility	19%
Others	2%
Assistance at home deliveries	
Untrained TBA	53%
Trained TBA	11%
Relatives/friends	22%
ANM/Nurse/LHV	8%
Doctor	5%
None	1%

Bihar and 34.6% in Uttar Pradesh. Almost a quarter (24.1%) of pregnant women did not receive any Tetanus Toxoid (TT) immunization. Two or more doses of TT, which is recommended as an essential component of antenatal care (ANC), were delivered to only 66.8 % of women. There are also concerns about the quality of ANC activities.

1.2.4.2 Deliveries

The skilled birth attendance rate in the country is around 40 % (RHS 40.2%, NFHS II 43.8%). Most deliveries attended by the skilled birth attendants occur at institutions. Institutional delivery rates were 34% (RHS 1998-99), 36% (NFHS II) and 39.8% (RHS 2002-03), according to two different surveys in 1998-99 and 2002-03.

In RCH Phase I, it was envisaged that efforts would be made to promote institutional deliveries both in urban and rural areas. The available data from the NFHS-I and II and the Rapid Household Survey suggest some improvement in the institutional deliveries, especially in states like Tamil Nadu and Andhra Pradesh. There are, however, a large number of districts in many states where the situation with regard to institutional deliveries is far from satisfactory.

While in Kerala over 90% of deliveries occur in institutions, in states like Uttar Pradesh, Rajasthan, Orissa and Bihar, the majority of deliveries take place at home, conducted by untrained personnel.

1.2.4.3 Emergency obstetric care

The RCH Phase I program aimed at operationalizing 1724 FRUs for emergency obstetric care. However, the progress has been far from satisfactory (Table 1.9). The major hurdles have been poor availability of specialists and difficult access to blood banks.

1.2.4.4 Post-partum care

At present the post-partum care of mothers is very deficient. Only 16.5% women received a post-partum check up within two months of delivery (NFHS II). Of these, less than one third were seen within the first post-partum week, a period associated with high complication rate. There was no systematic effort in RCH Phase I to implement post-partum care for women at home.

Table 1.9 Status of FRUs (FRUs surveyed 760; Facility Survey 1999)

Feature	Fulfilled (%)
Infrastructure	
Tap water	50
Electricity	96
Generator	71
Phone	80
Delivery facilities	89
Aseptic LR	36
OT	70
Gynae OPD	63
Linkages with district blood bank	17
Staff	
Obstetrician	48
Pediatrician	37
Anesthetist	22
Gen M.O.	89
One physician trained in EmOC/NBC	17/22
Utilization	
Utilized as referral facility	34

1.2.4.5 Status of different schemes

The provision of additional ANMs, staff nurses on contract, and the hiring of safe motherhood consultants succeeded in only a few states. Most states were unable to hire anesthetists for FRU work due to the non-availability of candidates. Tamil Nadu and Andhra Pradesh succeeded in starting 24-hour delivery services at PHCs/ CHCs. In most states, the referral transport funds made available to panchayats remained unutilized. The experience with RCH camps has been mixed – while some states like Tamil Nadu and Delhi reported excellent response, others thought it disrupted routine work.

1.2.4.6 Safe abortion

Abortion is a significant medical and social problem in India. An ICMR study (1989) documented that the rates of safe (legal) and unsafe (illegal) abortions were 6.1 and 13.5 per 1000 pregnancies, respectively. It is evident that perhaps two-thirds of all abortions take place outside the authorized health services by unauthorized, often unskilled providers.

Whether spontaneous or induced, abortion has been a matter of concern over many decades now, particularly because of sepsis and other complications associated with it. Nine percent of maternal deaths, i.e. over 10,000 each year, are attributed to complicated abortions. This is a preventable tragedy. This is also an indication of the unmet need for safe abortions. The National Population Policy 2000 underlines the provision of safe abortions as one of the important operational strategies.

The Medical Termination of Pregnancy Act was passed by the Indian Parliament in 1971 and came into force from April 1, 1972. The aim of this Act was to reduce maternal mortality and morbidity due to unsafe abortions. The MTP Act, 1971 lays down the conditions under which a pregnancy can be terminated and the place where such terminations can be performed. A recent amendment to the Act (2003) includes decentralization of power for approval of places, as MTP centers, from the states to the district level with the aim of enlarging the network of safe MTP service providers. The amendment also provides for specific punitive measures for performing MTPs by unqualified persons and in places not approved by the government.

Available service data indicates that, following an initial rise, the number of reported MTPs have remained around 0.5-0.7 million in the last decade. The estimated number of illegally induced abortions in the country is in the range of four to six million. There has not been any substantial decline in the number of illegal abortions, reported morbidity due to illegal abortion or the share of illegal abortions as the cause of maternal mortality. The management of unwanted pregnancy through early and safe MTP services as envisaged under the Medical Termination of Pregnancy Act is an important component of the ongoing RCH Program.

Under the RCH program, actions were initiated to expand and improve the MTP facilities and their utilization, and to make safe abortion services accessible to all women in the country, particularly in the rural areas. Assistance has been provided for skill-based training to doctors in MTP techniques and the supply of MTP equipment. The guidelines for MTP up to eight weeks, using the Manual Vacuum Aspiration technique, have been developed to enable MOs to provide safe abortion services using this simple and safe technique at the PHC level and above. Likewise, guidelines for the use of RU-486 with Misoprestol have been developed to ensure safe medical abortion in early pregnancy.

1.2.5 Looking towards the future: Lessons from international experiences in reducing maternal mortality

1.2.5.1 Interventions that work

In order to accelerate the decline of maternal mortality all women must have access to high-quality delivery care.

High quality maternal care has **three key** elements, namely, a skilled attendant at delivery, access to EmOC in case of a complication and a referral system to ensure that those women who experience complications can reach life-saving EmOC in time (Table 1.10).

Table 1.10 Keys to Saving Maternal Lives

1. Skilled attendant at delivery
2. Access to emergency obstetric care
3. Effective referral system

Skilled attendants at delivery

The term 'skilled attendant', as per the UN definition, refers exclusively to people with midwifery skills (for example, doctors, midwives, nurses) who have been trained to proficiency in the skills necessary to manage normal deliveries and diagnose, manage or refer complications. Ideally, the skilled attendants live in, and are part of, the community they serve. They must be able to manage normal labor and delivery, recognize the onset of complications, perform essential interventions, start treatment, and manage the referral of mother and baby to superior facilities for interventions that are beyond their competence or not possible in a particular setting.

It should be noted that TBAs, even after training, do not fulfill the criteria of a skilled birth attendant.

Skilled attendants can prevent maternal complications, disability and deaths by a variety of mechanisms, namely, conducting deliveries using scientific methods (including clean and safe procedures, and active management of the third stage), detecting obstetric emergencies early, providing obstetric first aid and ensuring the quickest possible transfer to a location where EmOC can be provided.

Thus, for most of the potentially fatal obstetric complications, the skilled attendant must have the backup of a functioning health care system in order to save the woman's life. No matter how skilled the attendant is, if s/he is performing deliveries in a setting without appropriate and adequate drugs, equipment and infrastructure to institute EmOC – and cannot get his/her patients quickly to that care – a certain proportion of patients are likely to die. The large majority of maternal deaths entails this kind of unexpected complication and therefore falls into this category.

Emergency Obstetric Care (EmOC)

Even under the very best of circumstances, with adequate nutrition, high socioeconomic status and good health care, a substantial proportion of pregnant women will experience potentially fatal complications; even more so in rural communities. In two studies in rural Maharashtra, 15% of women who delivered in rural homes developed complications that demanded EmOC. Most of the obstetric emergencies arise in labor.

Referral systems

Widely available, good quality EmOC is necessary, but not sufficient to reduce maternal mortality. Appropriate utilization is also necessary. A helpful way to analyze the barriers to utilization is through the "Three-Delays Model". Once a complication occurs, the key to saving a woman's life is to get her adequate care in time. The delays leading to death can be divided into:

- Delay in deciding to seek care
- Delay in reaching care
- Delay in getting treatment at the facility

One important strategy to reduce delays is the strengthening of the referral system. This requires adequate information and communication from the household to the birth attendant and up through the level of a comprehensive EmOC facility, as decisions are made. It also implies the need for an effective and readily available transportation system and the existence of EmOC facilities close enough to every community to be reached in time. Finally, it implies a system with providers trained, equipped and supported to provide the services appropriately at each level, as well as a system in which patients choose and are ultimately treated at the level in that system, which is most appropriate for their conditions.

Not all interventions are equal

There are multiple additional interventions that will be useful in promoting a healthy pregnancy, and that contribute to women's overall health and to the birth of a healthy newborn. It is important to recognize, however, that these interventions do not necessarily have a significant impact on maternal death. For example, Tetanus Toxoid immunization of the mother will prevent tetanus for both the baby and mother; however, while tetanus is a significant cause of neonatal mortality, it accounts for only a tiny proportion of the total maternal deaths. Another example is anemia. It is estimated that approximately half of the pregnant women in developing countries are anemic, a condition often due to malaria or parasites and not simply a lack of iron rich foods. A recent review of the evidence on anemia and maternal mortality found that there is a strong, probably causal, relationship between severe anemia and maternal deaths, but little or no relationship between moderate anemia and maternal deaths.

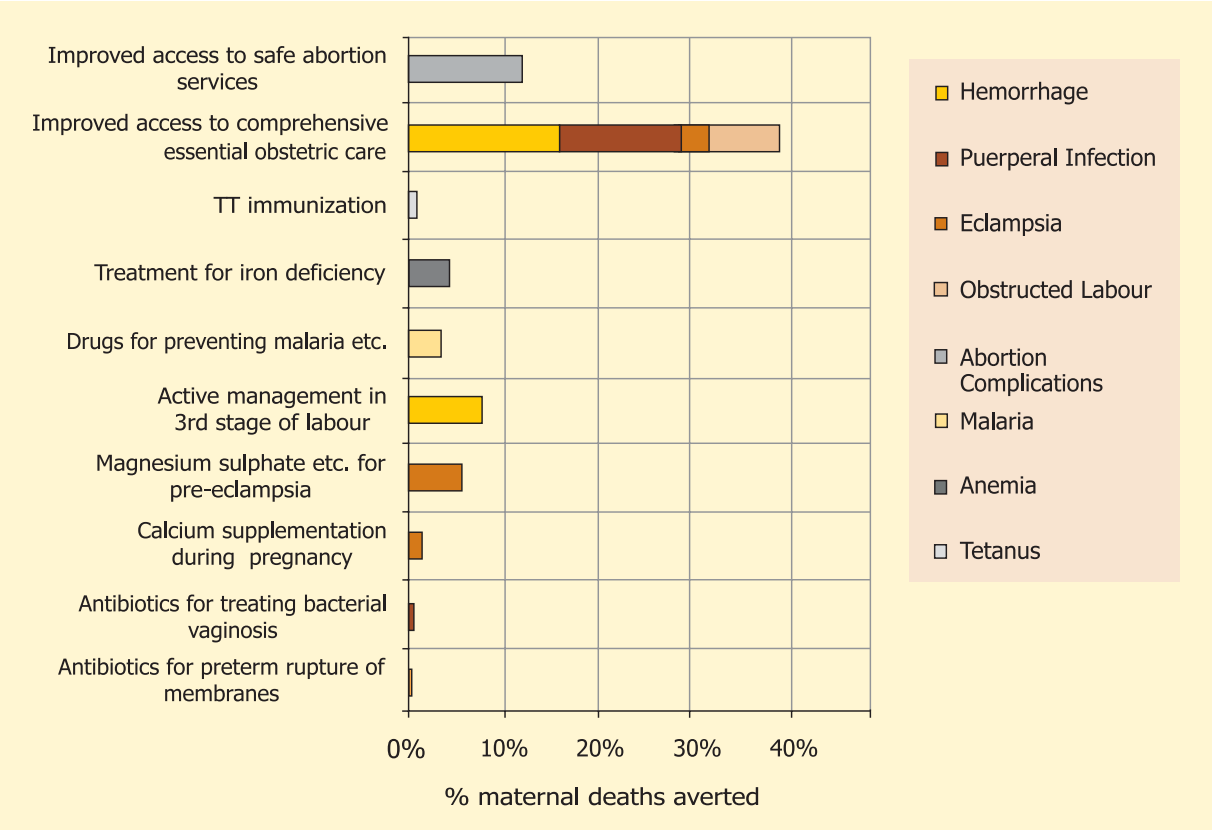
1.2.6 Strategic choices for India

India is faced with the biggest challenge in safe motherhood. The national goal is a nearly three-fourths reduction in maternal deaths by 2010.

Almost all skilled birth attendants in India are available solely through healthcare institutions, both government and private.

At present the country has very few skilled birth attendants at the village level. Some ANMs conduct deliveries at sub-centers or at homes. ANMs, assigned to a population of 5000, perhaps cannot conduct all the deliveries even if they reside at the place of their posting. Most ANMs are preoccupied with non-midwifery tasks and do not stay in their field areas. The community skilled birth attendant cadre is still at the drawing board stage.

Figure 1.3 Full Utilization of Existing Services would Dramatically Reduce Maternal Deaths



Source: Wagstaff and Claeson 2003

The lowest medical facility in the government sector is a PHC manned by a MO and a LHV. It is therefore logical to strengthen PHCs as sites for conducting deliveries and providing obstetric care for all complications. The provision of 24 hours nursing care along with the strengthening of infrastructure and supplies can convert PHCs into 24-hour delivery areas.

The next higher level would be the CHCs, many of which are being designated as FRUs. Manned by specialists (obstetricians, anesthetists, pediatricians), general MOs and nurses, FRUs are expected to provide comprehensive EmOC. This was mandated in the CSSM and RCH Phase I project and needs to be accomplished as a mission in RCH Phase II.

A functional referral system is essential to connect the community and different levels of facilities with each other. This component of the survival pathway has to be strengthened. Most of the functional EmOC facilities today are in the private sector. They should be made accessible to poor patients.

It is said that the best index of a functioning health system in a country is the state of maternal health services. Health system strengthening is the foundation on which better care for pregnant women will be operationalized.

1.2.7 RCH Phase II strategies to reduce maternal mortality

Guiding principles

The following principles will guide the planning and implementation of maternal health strategies in RCH Phase II.

- **Equity** - The focus will be on the poor and other vulnerable sections of the society.
- **Evidence-base** - Interventions included in the program would be evidence-based.
- **Continuum of care** - The maternal health strategy would be a complementary mix of community and facility-based interventions.
- **Health system approach** – *The* strengthening of the health system will be at the core of maternal health strategy.
- **Integrated services** - Maternal health interventions will be integrated with other components of the RCH program, including newborn and child health and family planning.

Objectives

- Improve access to skilled care and emergency obstetric care
- Improve coverage and quality of antenatal care
- Increase coverage of post-partum care

Strategies

1.2.7.1 Enhance availability of facilities for institutional deliveries and Emergency Obstetric Care (EmOC)

Expansion and strengthening of facilities for institutional deliveries and EmOC will be given the highest priority in RCH Phase II. Two levels of institutions will be targeted, namely, i) PHCs and CHCs for 24 hour delivery services including management of common obstetric complications, emergency care of sick children and referral and ii) FRUs for emergency obstetric and child care.

- ***Operationalize all CHCs and at least 50 % of PHCs for providing 24 hour delivery services including the management of common obstetric complications, emergency care of sick children and referrals***

  By 2010, all CHCs and at least 50 % of PHCs should be providing 24-hour delivery services including the management of common obstetric complications and emergency care of sick children. These facilities would also provide services for family planning, safe MTPs and RTIs/STIs as described in relevant sections.

  A UNFPA project in seven districts in Rajasthan has demonstrated a rise in met need for EmOC from 8.8 % in 2000 to 14.3 % in 2003 (an increase of 62%). These experiences will be built on, replicated and scaled-up nationwide.

  Suitable PHCs and non – FRU CHCs will be identified by the state government. Those with good access, transportation links and some existing infrastructure will be chosen. Equity consideration will be addressed by ensuring that underserved regions including the backward, tribal, difficult-to-reach areas are well covered.

  Infrastructure will be strengthened to an optimum level. Basic equipment for labor/delivery room and for newborn care will be provided. A newborn care corner will be developed. Adequate supplies

of essential drugs would be ensured. An ambulance (outsourced or otherwise) would be available round-the-clock for transportation of sick mothers and children to and from the community and referral centers as needed.

Guidelines to operationalize the above-mentioned services at these facilities have been developed and disseminated to the states. The essential criteria are the availability of uninterrupted services 24 hours a day, 365 days a year.

The team of PHCs would consist preferably of two MOs, who would be assisted by a LHV and nurses for round-the-clock services. Nurses would be the key functionaries who would provide a 24-hour midwifery cover under the supervision of MOs. The CHCs may have specialists in addition to the PHC staff. Group D staff (nurse aide/helper) would also be engaged to provide support for maintaining asepsis, housekeeping and waste disposal. Wherever necessary, staff including doctors and nurses could be hired on a contractual basis. If nurses are not available, ANMs could be deployed. A laboratory attendant would be provided for hemoglobin testing, urine examination, blood grouping and making etiological diagnosis of RTIs/STIs. Training will be provided for selected skills to each category of the staff as per the training needs assessment.

Patient care guidelines for the care of women, newborns, and children would be provided. Evidence-based interventions such as the use of a partogram and active management of the third stage will be implemented. Guidelines for pregnancy care and the management of common obstetric complications by medical officers, as also guidelines for antenatal care and skilled attendance at birth for ANMs and LHVs have been formulated.

- ***Operationalize Emergency Obstetric and Child Care services at 2000 First Referral Units***

  By 2010, a total of 2000 FRUs will be made operational to provide emergency obstetric and child care services 24 hours a day, 365 days a year.

  In RCH Phase II, the unfinished agenda of providing emergency obstetric and child care services at the sub-district level will be completed. This would meet the UN norm of one such unit for a population of 500,000 also taking into account the difficult-to-reach and backward areas. The FRUs will complement facilities in the private sector.

  Recently the DoH&FW has prepared guidelines for the operationalization of FRUs. States are being approached to develop FRUs accordingly. A certification process would be instituted to accredit the FRUs on the basis of infrastructure, staff, drugs, supplies and the quality of services.

- ***Ensure access to a blood bank at all district hospitals and a blood storage facility at FRUs***

  Blood transfusion is a life saving measure for a woman with hemorrhage and anemia. The provision of blood transfusion is an essential component of EmOC. Hence, it is essential that all FRUs and district hospitals have access to blood round the clock. Recently, the DoH&FW has developed guidelines for blood storage facilities. This has paved the way for establishing blood storage facilities at FRUs. In addition, it is recommended that each district hospital have a blood bank or access to one from where blood could be procured in less than 30 minutes.

- ***Train MBBS medical officers in anesthetic skills for EmOC***

  The DoH&FW has developed an 18-week course for training MBBS doctors in anesthetic skills for EmOC. The first batch has completed training at AIIMS (All India Institute of Medical Sciences) last year and there is a plan to train more MBBS doctors in anesthetic skills for EmOC in the program period.

- ***Train MBBS doctors in conducting cesarean sections***

  In view of the non-availability of obstetricians for manning the FRUs, the FOGSI (Federation of Obstetrics and Gynecological Societies of India) has developed a training course on basic obstetric care (including cesarean deliveries) for MBBS doctors. This important step in capacity building of doctors in comprehensive EmOC and the operationlization of FRUs will be implemented in a step-wise manner. A pilot phase would be followed by evaluation before scaling up.

- ***Provide emergency obstetric care services to BPL families at recognized private facilities***

  There is an urgent need to devise mechanisms for BPL families to avail of EmOC through the private sector. This is extremely important, because presently and for some more time to come, the availability of EmOC in the government sector may not be fully operational. In many parts of the country, especially in cities and towns, a vibrant private sector is well established. Ways need to be found to provide the poor access to these facilities. This issue pertains to the broader theme of public-private partnership in RCH Phase II, which is dealt with in greater detail in Chapter 3 of Document 2 of the PIP.

- ***Other recommendations***
  - Re-deploy specialists (obstetricians/ anesthetists/ pediatricians) from dispensaries and PHCs to FRUs and CHCs, where they can contribute to the emergency care of women and children.
  - Involve general surgeons in providing EmOC, wherever possible.
  - Use means of telecommunication (call phones/ emails) for making the referral system efficient.
  - Provide ambulances at PHCs/CHCs/FRUs (outsourced or otherwise).
  - Provide incentives to doctors and other staff to work at PHCs/CHCs/FRUs providing round the clock services. Improve living quarters and working conditions and recognize good performance.
  - Support with suitable delegation and empowerment MOs of PHCs and superintendents of CHCs/FRUs to run SCs/PHCs/CHCs/FRUs smoothly (to undertake minor repairs, ensure upkeep of premises, purchase drugs/ supplies from market in an emergency, hire transport to shift a sick mother, etc.).
  - Encourage the private sector to establish maternity hospitals / nursing homes in small towns.

1.2.7.2 Behavior change communication and community mobilization

Strategies

Janani Suraksha Yojana (JSY)

Janani Suraksha Yojana is the modified version of the National Maternity Benefit Scheme for pregnant women belonging to BPL (below poverty line) families. Its twin objectives are to: a) reduce maternal and infant mortality through the promotion of institutional deliveries, and b) protect the female fetus and child. The scheme is focused towards improving institutional deliveries among the BPL families by providing compensation to the beneficiaries for going to the institutions for deliveries and also for referral, transport and escort services.

Equally importantly, the scheme is also an attempt to reorient the role of TBAs as agents of change for positive community behaviors, to save pregnant women from morbidity and death.

The details of this scheme have been circulated seperately by the MoH&FW. In RCH Phase II, this demand-side strategy will be vigorously implemented to enhance utilization of the RCH services at the PHCs/CHCs/FRUs.

Other measures

- Educate communities about danger signs in the pregnancy, labor and post-partum period. Use media and other BCC/IPC strategies to enable individuals, families and communities to recognize signs of obstetric emergencies.
- Launch a sustained social mobilization effort for institutional deliveries with the help of PRIs, opinion leaders, NGOs, self-help groups as well as AWWs, link volunteers, ANMs and other stakeholders.
- Reward villages that achieve high rates of institutional deliveries and save mothers with obstetric emergencies through timely action.
- Promote referral transport for routine deliveries and emergency obstetric care. Make referral transport funds available with AWW/ANM.
- Map facilities; plan transport options; encourage innovative solutions by communities.

Provide skilled care to pregnant women at the community level

- *Promote deliveries by skilled births attendants at sub-centers and in the community*
  - In some states, many ANMs conduct deliveries at sub-centers and at homes. In RCH Phase II, efforts will be made to enable more ANMs to provide skilled care in these settings. States would be encouraged to devise suitable approaches to achieve this objective.
  - It is proposed to introduce a new cadre of Community Skilled Birth Attendants (C-SBAs). After a one-year training, a C-SBA would provide midwifery care as a 'practitioner' in the community. During RCH Phase II, this initiative would be piloted.
- *Permit ANMs to administer obstetric first-aid*

  ANMs are the front-line workers of the health system in India. Many of them conduct deliveries in the sub-center and home settings. All of them are likely to come across situations when a woman with obstetric emergency such as post-partum bleeding, eclampsia, or puerperal sepsis would be brought for advice and treatment.

  It has been recently approved that in order to save lives of women with obstetric complications in the community, the ANMs be permitted to use the following drugs:
  - Inj. Oxytocin
  - Inj. Magnesium Sulphate
  - Misoprostol (oral)
  - Oral Ampicillin
  - Inj. Gentamicin
  - Oral metronidazole

  They have also been permitted to start an IV infusion in an emergency.

It is important to ensure that systematic training is provided to ANMs prior to granting permission to use these drugs. Safeguards need to be provided to ensure that the drugs are administered only after ascertaining the clinical need. Once the decision is taken to grant the right to ANMs to use these drugs, appropriate supplies should be ensured to them.

Improve coverage and quality of antenatal care (ANC)

Antenatal care is important for not only the mothers, but also the newborn. There is a need to enhance the coverage and quality of ANC in the program. The aim would be to raise the proportion of pregnant women receiving three ANC check-ups to 80% from the present level of 44% (NFHS II).

Improve equity-driven coverage of ANC

- Make special efforts to reach the women of BPL, SC/ST and other marginalized groups.
- Target primigravida and adolescent mothers.
- Ensure fixed-day ANC activity/clinic in the community and in the facilities.
- Involve AWWs, women's groups, TBAs and other community partners to reach out to each pregnant woman, especially the above-mentioned groups.

Improve quality of ANC

- Ensure:
  - First check-up in first trimester
  - Total three or more check-ups
  - Two doses of TT
  - Ingestion of 100 tablets of IFA
- Ensure that the ANC includes all the recommended elements (history, abdominal palpation, BP, looking for edema, urine examination etc.) at all levels; and, in addition, blood grouping at the facility level).
- Improve counseling at ANC sessions focusing on:
  - Promotion of institutional deliveries
  - Danger signs of obstetric emergency
  - Birth preparedness: deciding about the place and attendant at delivery, where to go if an emergency arises, how transportation can be arranged, how money can be arranged for an emergency situation
  - Early care of the baby, including initiation of breastfeeding, drying and wrapping, delaying bath etc.

Strengthen skills of ANMs in improving quality of ANC, especially for counseling.

- Introduce sticks-based rapid estimation of hemoglobin and urine examination
- Provide mother-baby linked card to all, depicting key public health messages.

Strengthen post-partum care at the community level

Post-partum care will be improved significantly in RCH Phase II. It would be combined with newborn care. The emphasis would be on the home setting. A large proportion of births, especially among the poor, may continue to occur at home and even the institutionally- delivered babies and their mothers are likely to be discharged within a day or so after the delivery.

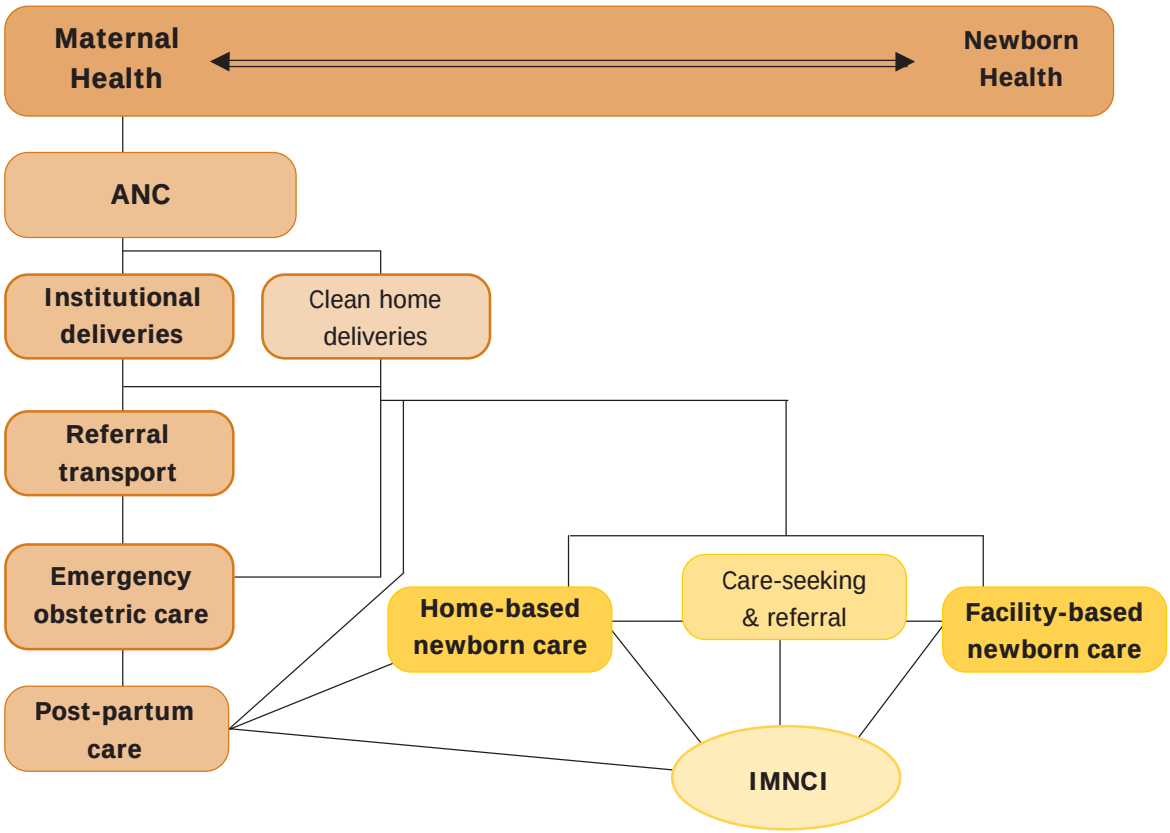
Home-based newborn care will be combined with home-based post-partum care of the mother.

The Janani Suraksha Yojana will give an opportunity for providing post-natal care to the community through community level workers. The **IMNCI** protocols will also provide PPC through field level workers like AWWs and advice on post-partum care. Figure 1.4 details maternal-newborn healthcare linkages.

The *key messages* for mothers would be on:

- Danger signs
- Nutrition
- Iron-folic acid supplementation
- Birth spacing
- Newborn care

Fig. 1.4 Maternal-Newborn Healthcare Linkages



Special schemes

RCH Phase I Schemes

In RCH Phase II, states are being provided the flexibility to adopt strategies for the delivery of services to suit their local situations. However, the schemes of RCH Phase I will continue to be available and implemented more effectively in RCH Phase II (see Table on next page).

Implement strategies for promoting safe MTP

Objectives

- Expand the network of facilities providing quality MTP services in the government and private sectors.
- Train more health professionals for conducting safe MTP
- Provide MTP counseling at the community level.
- Increase awareness regarding safe MTP in the community.

Strategies

- Community level
  - Spread awareness regarding safe MTP in the community and the availability of services thereof.
  - Enhance access to confidential counseling for safe MTP; train ANMs, AWWs and link volunteers to provide such counseling.
  - Promote post-abortion care through ANMs, link volunteers and AWWs while maintaining confidentiality.
- Facility level
  - Provide quality MVA (Manual Vacuum Aspiration) facilities at all CHCs and at least 50 % of PHCs that are being strengthened for 24-hour deliveries.
  - Provide comprehensive and high quality MTP services at all FRUs.
  - Encourage private and NGO sectors to establish quality MTP services.
- Other strategies
  - Promote the use of medical abortions at government and private institutions in early pregnancy; disseminate guidelines for the use of RU-486 with Misoprostol.

Strengthen Monitoring/ Records /Audit Procedures

- Monitor state and regional level MMR, and causes thereof
- Introduce mother-child linked card
- Conduct audit of maternal deaths at the hospital and community levels

Operations Research

- Develop models of operationalization of integrated obstetric and neonatal care at facilities.
- Develop models of a sustainable referral system for providing safe delivery services and emergency obstetric care.
- Develop models of private-public partnership in providing Em OC.
- Develop tools for maternal death audit and reporting.

Scheme	Comment
Contractual staff	This scheme has been found useful although implementation in different states has been very varied. Apart from ANMs, nurses, anesthetists and obstetricians, it could also be extended to pediatricians, general duty doctors, paramedic staff, helpers/cleaners and laboratory staff etc., wherever needed. The remuneration should be competitive enough to attract quality personnel. The scheme should encompass all levels from community/SC to district hospitals.
Safe Motherhood Consultant Scheme	Implementation of this scheme should be streamlined and strengthened. NGO's and professional bodies should be involved to identify the consultants. Ensure that the visit of the consultant is well advertised to attract the clients.
RCH Outreach Scheme	RCH outreach services should not be seen as a substitute for routine services. This initiative is meant to serve populations that are not readily accessible due to distant or inaccessible locations. Measures are to be taken to improve mobility.
RCH Camps	The experience with RCH camps has been mixed. Camps are good for awareness generation and outreach care, but there are possibilities that these may dislocate routine work and raise the expectations of getting all care at camps, which is not easy to implement and sustain. The states should take individual decisions in regard to their approach to holding RCH camps depending upon their experience and capacity.
Community Skilled Birth Attendant(C-SBA)	C-SBAs will be trained in a pilot program to provide a cadre of skilled birth attendants in the community. The pilot will be carefully evaluated and if found useful, the scheme could be scaled up in the late phase of RCH Phase II.
TBA involvement	India is in transition from home-based deliveries to institutional deliveries, and from unskilled birth attendants to skilled birth attendants. Nation's commitment to move towards skilled attendance and institutional deliveries is clearly enunciated in the NPP goals and the RCH Phase II objectives. It is true that TBAs contribution to reducing maternal mortality is modest, if any, but they have a very useful role as a community resource. It is, therefore, proposed to continue to engage TBAs in RCH Phase II. They will be involved in mobilizing communities for institutional deliveries according to the Janani Suraksha Yojana. With appropriate education, TBAs can also contribute towards newborn survival. They are accepted by the families and are involved in the care of the infants in the crucial first few days of the neonatal period. Experience from the community studies indicates that TBAs are critical for access to other care-providers. TBAs in low institutional delivery areas will, therefore, be educated and involved appropriately.

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1.3 Reproductive Tract Infections and Sexually Transmitted Infections (RTIs)/STIs)

1.3.1 The problem

Reproductive tract and sexually transmitted infections (RTI/STI) were not recognized as a public health problem until recently. Research conducted in India to document the magnitude of reproductive morbidity, has made the incidence of these infections more visible and brought them into the reproductive health agenda (Table 1.11). The spread of HIV infection and the role that RTI/STI plays in the transmission of HIV have also brought urgency to the problem.

1.3.2 Present strategies

To create awareness and generate demand for treatment of these infections, the National AIDS Control Organization, in close collaboration with the Department of Health and Family Welfare (DoH&FW), have been organizing the Family Health Awareness Campaign every six months. During the campaign, detection, management and referrals for RTI/STI cases are being undertaken.

The prevention, early detection and effective management of common lower reproductive tract infections have been included as a component of essential care through the existing primary health care infrastructure.

Table1.11 Summary of Studies on STI Prevalence Among Women in India

Study Population	Prevalence (%)								
	GC	CT	Syphillis	TV	HSV (clinical diagnosis)	HPV (clinical diagnosis)	Cervical dysplasia	HBV	HIV
Community-based									
Ever/currently married women	0.0 - 4.2	0.5 - 28.7	0.2 - 8.8	4.3 - 27.4	-	11.8	3.8% Grade III dysplasia	-	-
Unmarried & married women	0.3 - 3.9	5.2	0.2- 10.5	0.8 - 14.0	-	-	-	4.8	2.0
Facility-based and convenience samples									
STD clinic patients	1.3 - 16.5	-	29.3 - 43.3	-	4.0- 15.4	6.7 - 5.6	-	-	1.2 - 13.6
Sex workers	4.9 - 16.5	-	30.0 - 63.0	-	-	0.5	-	-	49.9
Gynecological OPD patients	1.0 - 5.5	0.2 - 31.3	4.4 - 5.6	0.4 - 26.0	0.3 - 25.0	0.6 - 42.4	9.2% severe dyskaryosis 5.4% invasive carcinoma	-	0.0
Antenatal patients	-	2.3	1.0 - 6.2	17.8	-	-	-	-	0.1 - 1.2
Gynecological patients with 'vaginitis' symptoms	0.0 - 2.6	2.6 - 12.2	2.2	1.6 - 17.6	-	-	-	-	-
Gynecological patients with cervical erosion	-	3.0	-	-	-	-	1.6% moderate dysplasia 13% severe dysplasia 1.8% malignant	-	-
Infertility and PID patients	0.1 - 11.0	0.5 - 4.2	0.5	0.5	-	-	-	-	-
Acceptors of tubal ligation	0.1 - 2.2	0.0 - 0.2	0.5 - 7.0	0.9	-		-		

NG= Neisseria gonorrhoeae; CT= Chlamydia trachomatis; TV= Trichomonas vaginalis; HSV= Herpes Simples Virus; HPV= Human Papilloma Virus; HBV= Hepatitis B virus; HIV= Human Immunodeficiency Virus

[From: UNFPA, Population Council. Reproductive tract infections: a guide for program managers. New Delhi 2001]

The DoH&FW has provided necessary drugs for treatment and also inputs to fill the gaps in laboratory support in the PHCs/CHCs. However, the upgradation of the health care personnel's skill training has lagged behind in most states. The DoH&FW has coordinated their efforts with NACO. NACO provides the input for diagnosis and management of RTI/STD at and above the district level. To strengthen the services for RTI/STI at the sub-district level, the government is providing assistance in the form of training, drug kits, disposable equipment and provision for engaging two laboratory technicians per district, on a contractual basis at the FRUs.

The importance of prevention, early detection and effective treatment of RTI/STI is well recognized by public health experts, practitioners and the public themselves. Reliable easy to perform tests for the

accurate diagnosis of RTI/STI are available. Most of the infections still respond to commonly used antibiotics and chemotherapeutic agents. A beginning has been made in RCH Phase I that needs to be built on and RTIs/STIs control needs to be given a major thrust in RCH Phase II.

1.3.3 Strategies in RCH Phase II

Objectives

- Promote recognition and referral of women (and partners) with suspected RTI/STI.
- Strengthen services for the diagnosis and treatment of RTI/STI at PHCs, CHCs, FRUs and district hospitals.
- Strengthen synergy with NACO activities.

Note: A national consultation on developing guidelines for RTIs/STIs at different levels of the health system is on the anvil, based on which the operational recommendations for RCH Phase II will be made.

1.4 Newborn and Child Health

1.4.1 The National Population Policy Goal

- Reduce infant mortality rate (IMR) to <30 per 1000 live births by the year 2010 [Current level 64 (SRS 2002)].

Enabling goal

- Reduce neonatal mortality rate (NMR) to below 20 per 1000 live births by 2010 [Current level 44 (SRS 2000)].

1.4.2 Child survival and health challenge in India

Overview

India is faced with an unparalleled challenge in the area of child survival and health. The country contributes 2.4 million of the global burden of 10.8 million under-five child deaths, which is the highest for any nation in the world. Nearly 26 million infants are born each year, of whom 1.2 million die before completing the first four weeks of life and 1.7 million die before reaching the first birthday (Table 1.12).

It has been estimated that if the known, evidence-based interventions are taken to scale, 56% or more of the country's under-5 five child deaths can be averted (Jones G).

1.4.2.1 Why and when do children die?

The principal causes of neonatal deaths include: neonatal disorders, pneumonia, diarrhea and measles. Low birth weight and under nutrition are the most important risk factors of child mortality.

The first few days and weeks of life are the most risky. A recent ICMR study at five rural sites showed that a quarter of under-5 child mortality occurs by day three (Table 1.13). There is an overwhelming consensus in the country that saving newborn lives is critical to the success of the second "child survival revolution" in India.

Table 1.12: Newborn and Child Health Burden in India is Larger than any Other Country in the World

I. Mortality rates	
Under-five child mortality rate	95 per 1000 live births (NFHS 1998-99)
Infant mortality rate	64 per 1000 live births (SRS 2002)
Neonatal mortality rate	44 per 1000 live births (SRS 2000)
II. Annual Mortality Burden (approx.)	
Live births	26 million
Child deaths	2.4 million
Infant deaths	1.7 million
Neonatal deaths	1.2 million
III. Nutrition related statistics	
Low birth weight (LBW) infants	30%
Proportion of under-5 children who are:	
Underweight	47% (NFHS II)
Stunted	45% (NFHS II)

Neonatal and child mortality: trends and state-level differences

Since the early seventies, infant mortality rate has declined by almost half (Figure 1.5). The under-five child mortality rate also declined from 144 per 1000 live births (1978-83) to 95 per 1000 live births (1988-93).

Child health interventions such as immunization, oral rehydration therapy and increase in deliveries by skilled attendants have helped in savings millions of neonates and children since the seventies. Family planning services and the Integrated Child Development Services have played an important contributory role towards reducing child mortality in the country. This progress is also attributable to overall socio-economic development, improved educational status of the population and better access to healthcare in the government and private sectors.

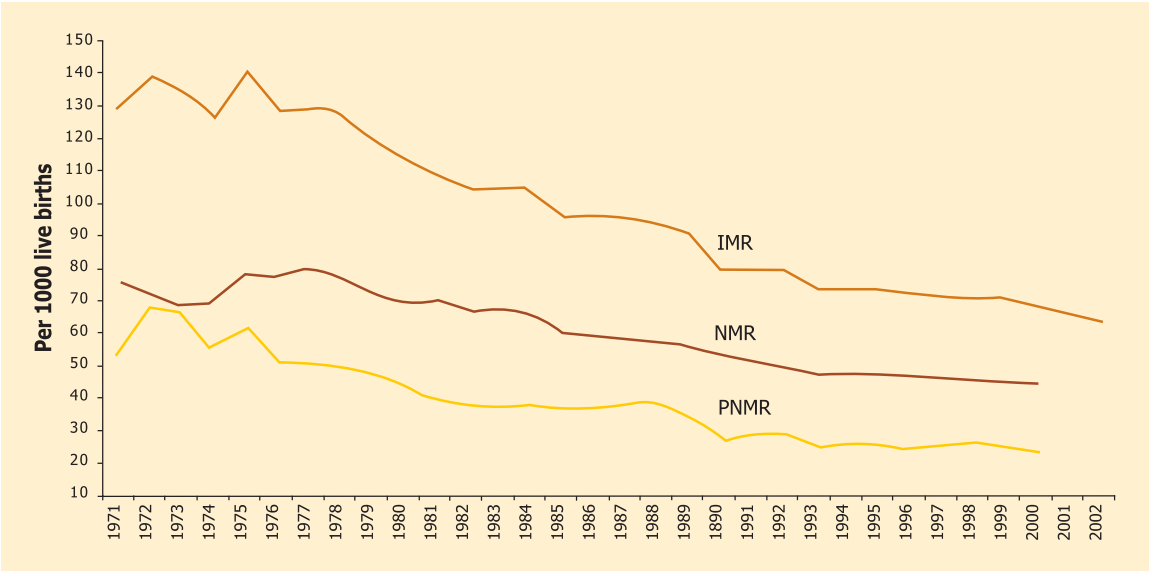
However, in recent years the rate of reduction in infant mortality has slowed considerably. The average decrease in IMR was around three points each year in the two decades preceding 1992. In the subsequent 10 years, the decline has been of the order of only 1.5 points per annum (Table 1.14).

Table 1.13: Timing of Under-5 Child Deaths*

Age completed	Under-5 child deaths (cumulative)
Day 1	20%
Day 3	25%
Day 7	37%
Day 28	50%
1 year	75%
5 years	100%

*Extrapolated from data extracted from an ICMR study. (2003)

Fig. 1.5: Trends in Infant Mortality Rate (IMR), Neonatal Mortality Rate (NMR) and Post-Neonatal Mortality Rate (PNMR)



The challenge in RCH Phase II is to accelerate reduction in childhood deaths to reach the national goals and Millennium Development Goals (MDGs).

India is a vast and heterogeneous country. There are wide variations in the level of infant and child mortality in different states. The highest rates are seen in the EAG states, notably in Madhya Pradesh, Orissa, Rajasthan, Uttar Pradesh and Bihar (Table 1.15).

1.4.2.2 Newborn health

Problem

The first four weeks of life are termed as the neonatal period. Neonatal mortality has declined significantly in India since the seventies largely due to maternal TT immunization leading to the near elimination of neonatal tetanus and also due to the gradual increase in deliveries at institutions and by skilled attendants. Between 1972 and 1992, the NMR declined by almost 30% (Table 1.14). However, the NMR in the last decade has become static, hovering around 45 per 1000 live births. This is a major cause of concern, and there is an urgent need to take steps to improve neonatal health and survival.

At the present rates, neonatal mortality constitutes nearly two-thirds of infant mortality and half of under-5 child mortality. With 1.2 million deaths of infants under four weeks of age each year, India accounts for 30% of the global burden of neonatal deaths – the highest in the world. The NMR shows a wide variation in different states the lowest being in Kerala (10) and the highest in Orissa and Madhya Pradesh (around 60).

Within the neonatal period, the first week is the most crucial. Three-fourths of all newborn deaths occur during the first week of life (early neonatal period).

The major causes of neonatal mortality are bacterial infections (52%), asphyxia (20%), premature birth (15%) and other cases (13%). Neonatal tetanus still causes over 48,000 deaths in the country (WHO 2000 estimates). Newborn deaths in the first week of life are predominantly caused by birth asphyxia and premature birth, whereas those after the first week are mostly due to bacterial infections.

Table 1.14: Trends in Infant Mortality Rate (IMR) and Neonatal Mortality Rate (NMR) per 1000 live births

Year	IMR	NMR	NMR as proportion of IMR
1972	139	72	51%
1982	105	67	64%
1992	79	50	63%
1993	74	47	63%
1994	74	48	65%
1995	74	48	65%
1996	72	47	65%
1997	71	46	65%
1998	70	45	63%
1999	70	45	64%
2000	68	44	65%
2001	66	N/A	N/A
2002	64	N/A	N/A

Irrespective of the primary causes of deaths, over three-fourths of neonatal deaths occur among infants who are born with low birth weight (weighing less that 2,500g at birth). In India, one-third of all neonates are low birth weight (LBW), this rate is among the highest in the world.

Only 34% births in India occur in institutions, while the remaining two-thirds take place at homes (NFHS II). The proportion of home births in rural areas is 75% and among the poor families is 80%. There is a clear relationship between the proportion of non-institutional deliveries and the neonatal mortality rate in different states. The higher the home delivery rate, the higher the neonatal mortality rate is. Thus, the challenge of improving newborn health is really in the home setting.

There is a wide variation in regard to the proportion of institutional deliveries in different states. In Kerala, the state with the lowest NMR, the institutional delivery rate is a high 93%. In Tamil Nadu the rate is 79%, while in Rajasthan, Bihar and Uttar Pradesh, the institutional delivery rates are under 25% (NFHS II).

Newborn care has for long been equated with the hospital-based care of babies requiring incubators and other expensive equipment. This is not so. The principles of newborn care are simple and eminently achievable through primary care. A study from Gadchiroli (Maharashtra) conducted by Dr. Abhay Bang and colleagues has shown that in the rural setting with a high rate of home deliveries and an NMR of over 60 per 1000 live births, it is possible to reduce NMR and IMR dramatically by 62% and 45%, respectively, over a period of three years by delivering a package of neonatal care interventions through community-based health workers (Lancet 1999).

Table 1.15: State-wise Neonatal, Infant and Under-Five Child Mortality Rates (Per 1000 Live Births)

State	SRS		NFHS II 1998 – 99		
	IMR 2002	NMR 2000	NMR	IMR	U-5MR
INDIA	**64**	**44.4**	**43.4**	**67.6**	**94.9**
Andhra Pradesh	62	45	43.8	65.8	85.1
Assam	70	47	44.6	69.5	89.5
Bihar	61	42	46.5	72.9	105.1
Gujarat	60	42	39.6	62.6	85.1
Haryana	62	38	34.9	56.8	76.8
Himachal Pradesh	58	31	22.1	34.4	42.4
Karnataka	55	40	37.1	51.5	69.8
Kerala	10	10	13.8	16.3	18.8
Madhya Pradesh	85	59	54.9	86.1	137.6
Maharashtra	45	33	32.0	43.7	58.1
Orissa	87	61	48.6	81.0	104.4
Punjab	51	29	34.3	57.1	72.1
Rajasthan	78	49	49.5	80.4	114.9
Tamil Nadu	44	36	34.8	48.2	63.3
Uttar Pradesh	80	53	53.6	86.7	122.5
West Bengal	49	31	31.9	48.7	67.6
Delhi	32	N/A	29.5	46.8	55.4
Jammu & Kashmir	47	N/A	40.3	65.0	80.1
Arunachal Pradesh	40	N/A	41.8	63.1	98.1
Manipur	17	N/A	18.6	37.0	56.1
Meghalaya	60	N/A	50.7	89.0	122.0
Nagaland	N/A	N/A	20.1	42.1	63.8
Sikkim	39	N/A	26.3	43.9	71.0
Goa	19	N/A	31.2	36.7	46.8

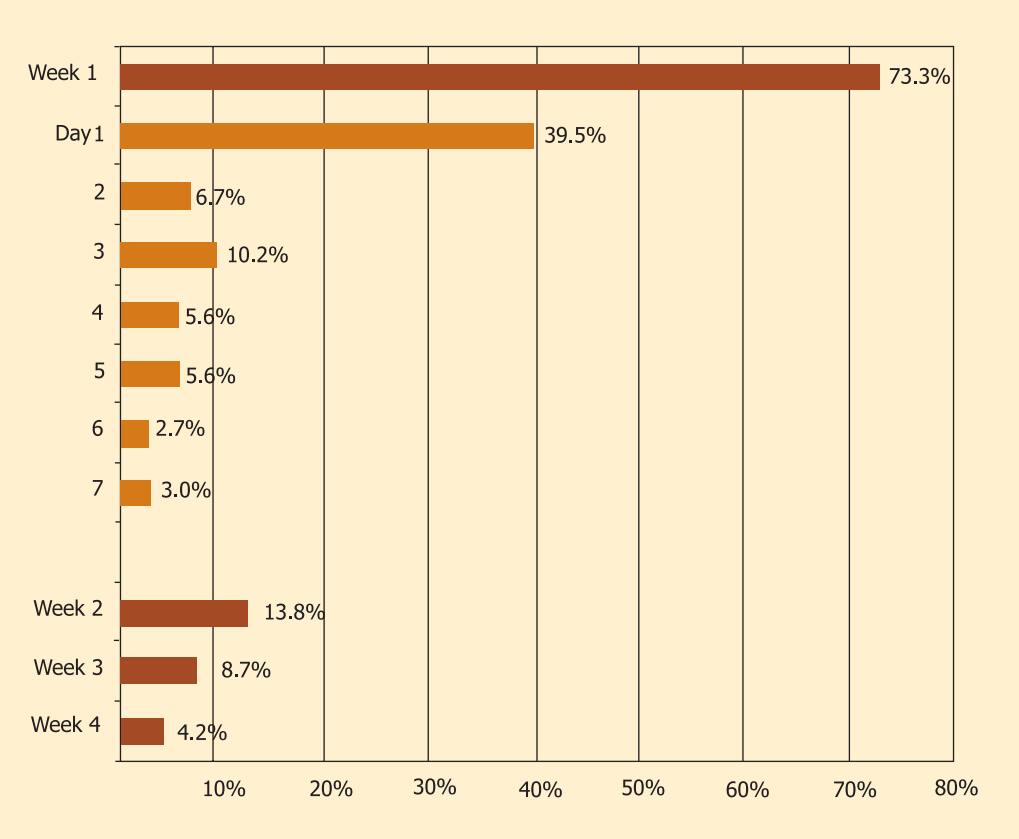
*N/A: Not available

1.4.2.3 Essential Newborn Care (ENC) in CSSM and RCH Phase I Projects

Essential newborn care (ENC) became a part of the child survival strategy in the Child Survival and Safe Motherhood program and continued into the RCH program. The focus was on the strengthening of facilities with equipment and trained of physicians. The operationalization of newborn care was accomplished in 80 districts in RCH Phase I. In addition, the integrated skills training modules of ANMs and MOs briefly cover ENC. In 142 districts of 17 states having safe delivery rates of less than 30%, a TBA training program has also been going on since 2001.

Newborn health interventions in RCH Phase I was limited in scope, and primarily facility-focused. The community-based interventions were neither comprehensive nor implemented effectively. There is an urgent need to orient the program to the care of the newborn infants at homes where most neonates take birth, and many fall sick and die.

Fig. 1.6: Timing of Neonatal Deaths (n=1387)



(Provisional data from ICMR study, as home-based care of young infants)

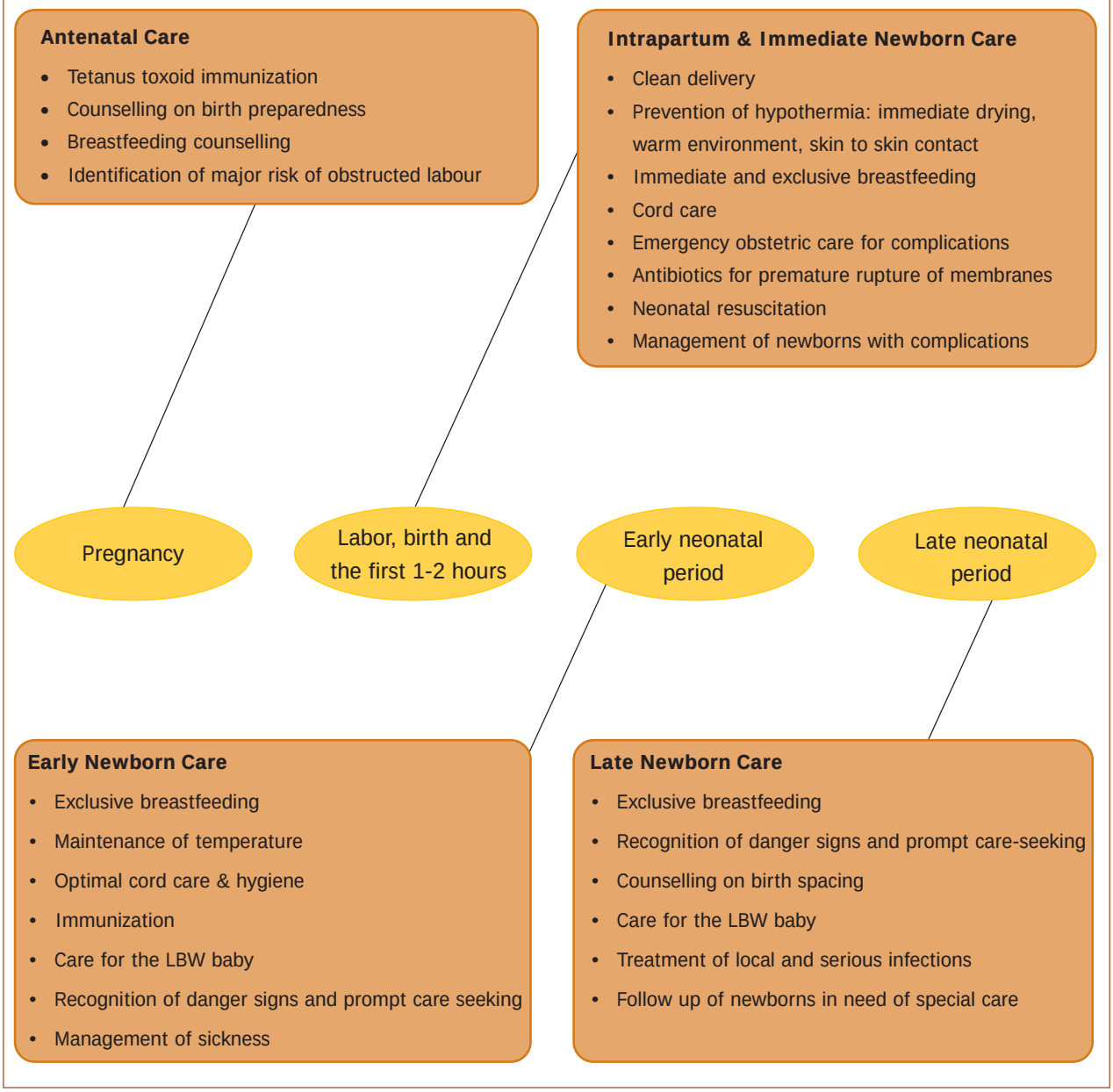
1.4.2.4 Interventions that save newborn lives

Newborn health is inseparable from maternal heath. Maternal problems such as under nutrition, young age, infections, anemia, hypertensive disease and tobacco abuse are associated with low birth weight. Complications of labor and delivery not only cause maternal morbidity, but may also lead to fetal compromise, birth asphyxia and neonatal mortality.

A skilled attendant at delivery and EmOC are the most important maternal health interventions with enormous benefit to newborn survival and health. These two interventions form the bedrock of maternal health in RCH Phase II that would help to save thousands of neonates.

Figure 1.7 depicts the model of essential newborn care that forms the basis of the recommendations in this PIP. ENC needs to be delivered wherever the neonates are, at homes or in healthcare facilities. The principles of ENC do not change; only the delivery mechanisms and the degree of sophistication vary. In RCH Phase II, the focus will be on the home-based newborn care recognizing the reality of home births in much of the country, and the fact that even babies delivered at facilities return home in a day or two, and remain vulnerable to excess morbidity and mortality especially among the poor families. Home visits by providers AWWs (or link volunteers) with the help of TBAs (wherever relevant) would be ensured for neonates on days 1,2,7,14 and 28 in RCH Phase II. At these contacts, the AWW (or link volunteer) would provide home-based care to both the baby and the mother (using IMNCI approach).

Figure 1.7: Effective Newborn Health Interventions



Neonatal survival calls for ensuring a continuum of care from maternal interventions to neonatal interventions, and from home-based interventions to the facility-based care.

Age at delivery and birth spacing have a profound positive impact on newborn survival and health. NFHS II data show that NMR (per 1000 live births) is 63 if the maternal age at delivery is <20 years, 55% higher than that if the mother is 20-29 years old. Likewise, the NMR of 36 (when birth interval is 2-4 years) becomes almost double, when the birth interval is less than two years.

1.4.2.5 Scenario-based approach on prioritizing newborn health strategies

Among newborn health interventions, there are some that are relatively easy to implement than others. Drying and wrapping the neonates at birth can be implemented more readily than resuscitation with a bag and mask, kangaroo mother care is more doable than incubator-based care, cotrimoxazole or

amoxicillin treatment is easier than treating infants with gentamicin injections. The promotion of clean delivery kits and exclusive breastfeeding would take priority over creating newborn units in resource-constrained circumstances. If a health system cannot achieve sufficiently high levels of maternal TT coverage and reduce neonatal tetanus drastically, it is unlikely that it can operationalize PHCs effectively for sick newborn care. The capacity of the health system is thus an important determinant of the effectiveness of the program.

In view of the varying feasibility of the newborn health interventions and the health system capacity, it is proposed that a *scenario-based approach* may be taken at the state/ district level in prioritizing newborn health strategies. States with a high neonatal mortality rate (NMR), for example over 50 per 1000 births, are more likely to have deliveries at homes, often by TBAs and would have a high post-neonatal mortality due to poor conduct of the simple child survival interventions. These states may work with TBAs for improving home practices in newborn care, eliminate tetanus neonatorum, and promote clean deliveries, exclusive breastfeeding and birth spacing. In states with a NMR of 25-50 per 1000 live births the emphasis should be on home-based newborn care with the help of TBAs, AWWs and link volunteers. As the NMR declines, institutional care of newborn infants will become increasingly critical for achieving further improvements in newborn survival. In areas where the NMR is under 25 per 1000 live births, institutional care supported by home-based care would be appropriate.

Thus, newborn health action in states like Uttar Pradesh or Rajasthan with predominantly home deliveries may be in the community settings, while the major thrust of newborn health strategies in a state like Tamil Nadu, where institutional delivery rates have picked up, will be further strengthening facilities for newborn (and maternal) care. This stratified approach based on different newborn health status and health system scenarios may be applied in different states (or districts) in consultation with experts and program managers in RCH Phase II.

1.4.2.6 Diarrheal disease

Diarrhea is one of the leading causes of death among children. NFHS II showed that as many as 19% of children under the age of three suffered from diarrhea in the preceding two weeks. Most of these deaths are due to dehydration caused by loss of water and electrolytes in the stools. Dehydration can be prevented and treated by timely and adequate replacement of fluids. Persistent diarrhea contributes to malnutrition, which further enhances the risk of morbidity and mortality. Dysentery is an acute from of diarrheal disease due to invasive bacteria that leads not only to dehydration, but also to multi-system manifestations, which may prove fatal. Dysentery occurs in 14% of children who suffer diarrhea (NFHS II).

The Oral Rehydration Therapy (ORT) program was started in 1986-1987. The main objective of the program was to prevent death due to dehydration caused by diarrheal disease. Health education aimed at rapid recognition and appropriate management of diarrhea has been a major component of the CSSM and RCH Phase I project. ORS packets are provided at sub-centers as part of the drug kit-A, under the RCH program. The use of home available fluids and ORS has resulted in a substantial decline in the mortality associated with diarrhea from an estimated 1.0 -1.5 million children every year prior to 1985 to six to seven lakh deaths in 1996. In addition, social marketing and supply of ORS through the public distribution system is being done in some states.

Data from NFHS II suggests that the use of ORS in diarrheal episodes continues to be low, at only 27% (NFHS II), coverage is shown in Table 1.16. The usage of ORS was very low among children who had diarrhea (NFHS II 26.8%), even though 62% of mothers had knowledge about ORS (NFHS II).

Table 1.16: ORS Usage - Percentage of Mothers whose Children got ORS Packets as Treatment of Diarrhea

State/UT	ORS use
INDIA	**26.8**
Major States	
Andhra Pradesh	39.6
Assam	37.1
Bihar	15.4
Gujarat	28.9
Haryana	25.7
Karnataka	34.3
Kerala	47.9
Madhya Pradesh	29.8
Maharashtra	33.2
Orissa	35.1
Punjab	42.3
Rajasthan	20.3
Tamil Nadu	27.9
Uttar Pradesh	15.8
West Bengal	40.5
Smaller States	
Arunachal Pradesh	40.2
Chattisgarh	N/A
Delhi	39.1
Goa	55.6
Himachal Pradesh	45.6
Jharkhand	N/A
J & K	47.5
Manipur	50.7
Meghalaya	22.4
Mizoram	44.7
Nagaland	29.7
Sikkim	27.0

Source: (NFHS II 1998-99)

1.4.2.7 Acute Respiratory Infections (ARI)

Acute respiratory infections (ARI) in children can involve the upper respiratory tract (nose, throat) or the lower respiratory tract (bronchi, lungs). The lower respiratory tract infections (broadly termed as pneumonias) are a major cause of deaths of infants and children in India accounting for about 30% of under-five deaths. In NFHS II, 19% children under the age of three years experienced cough accompanied by fast breathing (indicating lower respiratory tract infection) during two weeks preceding the survey. Timely treatment based on well-researched algorithms can save most children with ARI. The majority of cases of ARI have non-severe disease, and can be managed in the community with oral co-trimoxazole. Severe ARI cases require urgent referral to a facility for injectable antibiotic therapy and supportive care.

The ARI control program was initiated as a pilot project in 14 districts in the country in 1990. Ten more districts were added in 1991. In 1992, the ARI control strategy became a part of CSSM program, which

continued into the RCH Phase I project in 1997. Co-trimoxazole tablets are being provided at sub-centers and above. ANMs are being trained to treat children with ARI. The Rapid Household Survey (2002) showed that the utilization of government facilities for seeking healthcare for children with ARI was very low (14%). On the contrary, NFHS II reported that the proportion of children with ARI taken to a facility or a provider was a high 64%.

Research has shown that community health workers can effectively manage ARI and bring down IMR (Lancet 1992). In RCH Phase II the aim would be to translate these findings and experiences in ARI implementation to dramatically reduce ARI deaths using the IMNCI approach.

1.4.2.8 Challenges in managing sick neonates and children

There is no magic bullet that would prevent all the morbidity in neonates and children. Many of them will fall ill. While preventive and promotive approaches will be continued with added vigor and intensity, management of sick neonates and children at household community and facility levels will receive emphatic attention in RCH Phase II. It is conceivable to achieve a dramatic reduction in deaths due to diarrhea, ARI, severe malnutrition and neonatal sepsis in the next five years. The challenges in managing sick neonates and children are summarized in Table 1.17. RCH Phase II program aims to address them effectively.

Table 1.17: Some Key Issues in Managing Sick Neonates and Children

How to:
■ Promote early recognition of sickness, including severe malnutrition
■ Promote healthy household practices (e.g. food and fluids in diarrhea, warmth for sick newborn), and avoid harmful practices
■ Promote early care seeking
■ Ensure access at the community level to a provider who can manage/refer sick neonates/and children
■ Promote community/home-based care of mild to moderate illnesses that require no referral
■ Promote appropriate referral and ensure safe transport of neonates/children with severe disease
■ Make ORS more widely available, close to the source of demand
■ Involve AWWs as the first contact provider for sick neonates/children
■ Enable AWWs to treat children with diarrhea and ARI with ORS and co-trimoxazole, respectively
■ Enable ANMs to use gentamicin to treat neonatal sepsis
■ Ensure functional PHCs, CHCs and FRUs to cater to the care of sick neonates/children
■ Ensure care of sick neonates/children of BPL families in private facilities

1.4.2.9 Immunization

Introduction

India's Universal Immunization Program (UIP) is one of the largest in the world in terms of quantities of vaccine used, the number of beneficiaries, the number of immunization sessions organized, the geographical spread and diversity of areas covered.

Immunization is one of the most cost effective interventions for disease prevention. Traditionally the major thrust of immunization services has been the reduction of infant and child mortality. However, newer vaccines like the Hepatitis B vaccine is administered in infancy, gives lifelong protection against liver cancer and other complications of Hepatitis B infection in adults. Immunization is an important vehicle for health promotion. Immunization is thus not simply an item of national expenditure, but truly a national investment.

Situational analysis

The national policy of immunizing all children during the first year of life with DPT, OPV, BCG and typhoid-paratyphoid fever vaccine to complete the primary series of vaccination before reaching the age of one year was adopted in 1978, with the launching of the Expanded Program on Immunization (EPI). Its target was to increase immunization coverage in infancy to 80%. Subsequently the typhoid-paratyphoid vaccine was dropped. Tetanus Toxoid (TT) immunization of pregnant mothers was introduced in 1983.

The program was launched in 1985 in a phased manner to cover the entire country by 1990 under the Universal Immunization Program (UIP). The measles vaccine was added in 1985; and in 1990, vitamin A supplementation was added to the program.

The UIP was given the status of a National Technology Mission in 1986. A specific Immunization Strengthening Project (ISP) was designed to run from 2000-2003, which included three main components (Polio eradication, strengthening routine immunization and strategic framework development). The objectives of this three-year plan have mostly been achieved.

The impact of the UIP is measured in terms of vaccine preventable diseases (VPD) burden. Between 1984 and 2002 the infant mortality rate (IMR) in India has fallen from 104 to 66 deaths per 1000 live births. Over the last 15 years there has also been a general decline in the reported number of cases of the six main VPD, as can be seen in figure 1.

Despite the improvement indicated above, the stated goals were not fully achieved, thus there is an urgent need to address the immunization system deficiencies and emphasize the need for strengthening the system and vigilant monitoring and surveillance.

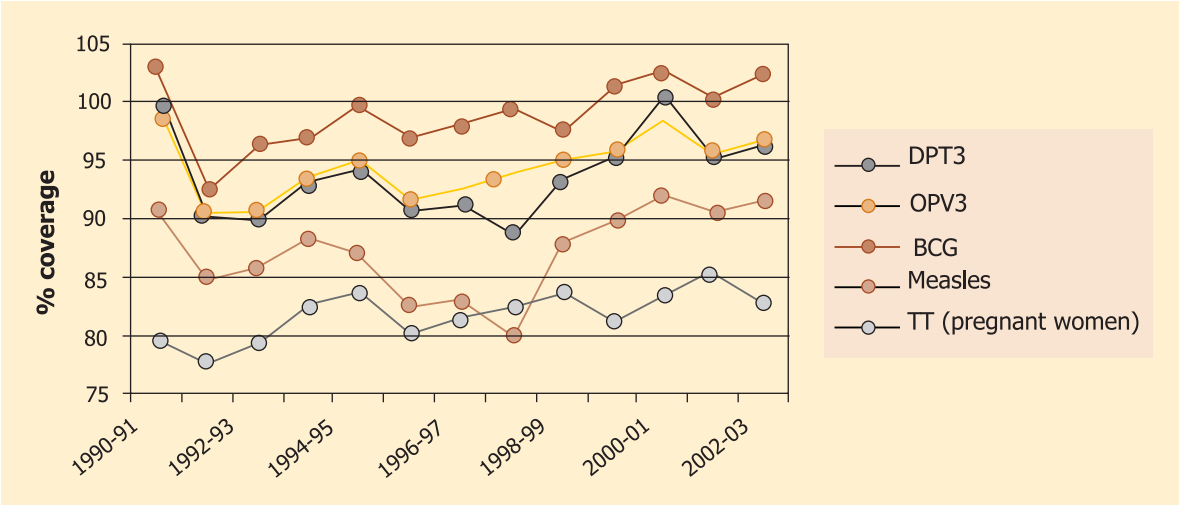
Current coverage rates and trends

The output of the UIP is measured in terms of antigen coverage and drop out rates.

- Antigen coverage rates are a measure of ‘access’ to immunization services.
- Drop out rates indicate service utilization and are useful to consider when prioritizing improvements for ‘acceptability’ of services.

Reported national antigen coverage: Figure 1.8 shows the national reported coverage for each antigen since 1990. The reported coverage rates have increased, with the exceptions of 1992 and 2001. BCG coverage rates have been over 100% for the last three years (perhaps due to under estimation of the denominator). The reported national BCG - measles drop out rate is 10% in 2002. In 2002, 56% of infants were fully vaccinated in the country.

Figure 1.8: Reported National Coverage Rates by Antigen 1990 - 2002.



Source: Evaluation and Intelligence Division MoH&FW.

Variations between states: The variation between states in the "fully vaccinated coverage" rates in 2001 – 2002 shows much lower coverage rates in the northern states of Uttar Pradesh, Bihar, Rajasthan and Jharkhand, in comparison to the southern states.

176 (72%) districts surveyed showed a decrease in full immunization rates over the five years; average decrease 15.4% (varied 0.1 – 64.2%)

66 (27%) districts surveyed showed an increase in full immunization rates over the five years; average increase 9.4% (varied 0.1 – 41.1%)

2 districts showed no change in full immunization rates

A drop in coverage rate is also seen at state level, as seen in Figure 1.9 showing % of districts in each state surveyed achieving >80% DPT3 evaluated coverage rates. This shows the states with the lowest % of districts surveyed achieving >80% DPT coverage in 2002-2003 are: Assam (0%), Bihar (0%), Jharkhand (0%), Madhya Pradesh (0%), Rajasthan (0%), Uttar Pradesh (0%) and West Bengal (12%). The states showing the ***greatest drops*** in % of districts achieving >80% coverage between 1998-99 and 2002-2003 are: Andhra Pradesh, Gujarat, Haryana, Madhya Pradesh, Maharastra and Orissa.

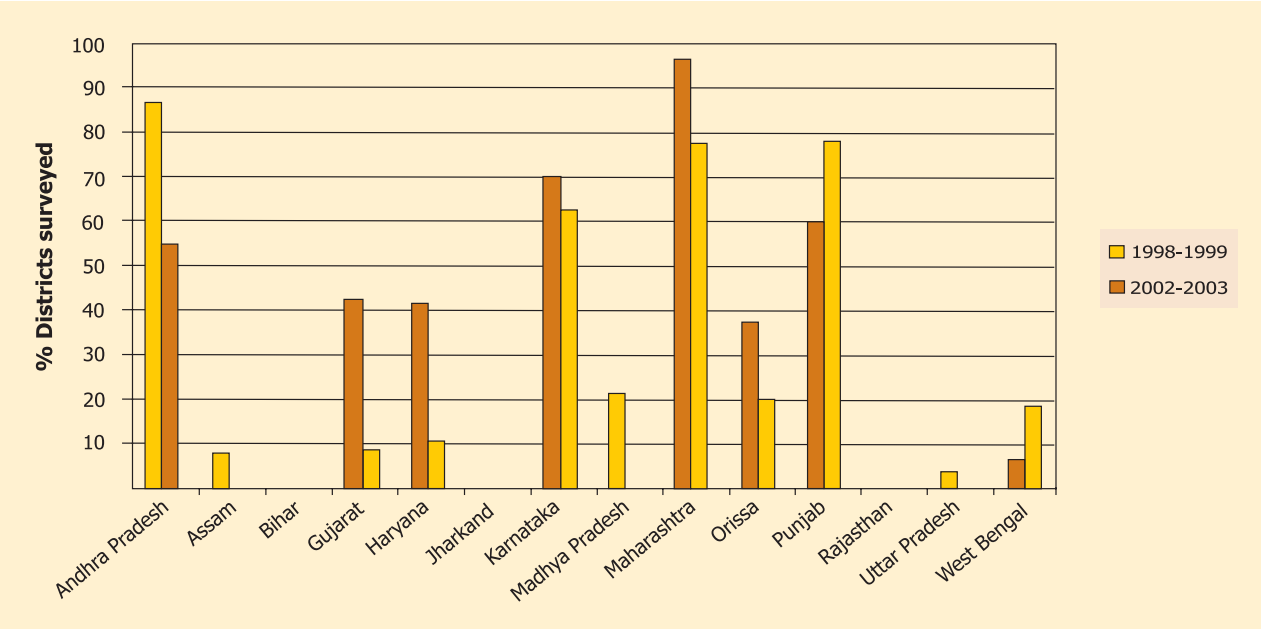
Drop out rates: In 2001, the average evaluated BCG – measles drop out rate by state was 14.4%. The drop out rate is an indicator of acceptability or demand for immunization services. Drop out rates were the highest in Andhra Pradesh (37.5%), West Bengal (27%) and Meghalaya (35%). Almost 6.3 million children who came into contact with immunization services (receiving BCG) in 2001 did not receive their measles vaccine. 93% of these infants live in 15 states and over half live in Andhra Pradesh, Uttar Pradesh, West Bengal and Bihar.

Constraints

The most common constraints are:

- Coverage not uniform
- Poor implementation
- Poor monitoring

Figure 1.9: % Districts Surveyed with >80% DPT 3 Coverage in Key States in 1998 - 99 and 2002 - 03



Source: Rapid Household Survey RCH project; International Institute for Population Sciences

- High dropouts
- Declining coverage in some major states
- Over reporting
- Injection safety
- AEFI monitoring
- Re-orientation of staff
- Cold chain replacement plan
- Unfilled vacancies of staffs at field level
- Surveillance of vaccine preventable diseases
- Vaccine logistics
- Maintenance of equipment

1.4.2.10 Breastfeeding and complementary feeding

Exclusive breastfeeding is the single most important child survival intervention. Breast fed infants have better nutritional status and lower rates of morbidity and mortality. Breast milk not only provides essential nutrients for the first six months of life, but also protects the child against infections and enhances child development.

WHO recommends exclusive breastfeeding for the first six months of life. Successful breastfeeding requires the initiation of breastfeeding soon after birth, and avoidance of pre-lacteals, supplementary water or top milk. The Baby Friendly Hospital Initiative launched since 1992, aims at promoting successful breastfeeding in the facilities where deliveries take place. However a lot more needs to be done to

promote breastfeeding in the community. According to NFHS II, the proportion of exclusively breast fed infants at four months of age was only 37% and that at six months a pathetic 19%. The delay in initiation of breastfeeding is almost a rule. Only 16% of mothers initiate breastfeeding within the desired one hour after birth, as against the Tenth Plan goal (2007) of 50%. As many as 63% of women do not feed neonates with colostrum, which is endowed with infection preventing properties.

From six months of age, the introduction of complementary food is necessary to meet the nutritional needs of infants. However, in a majority of children the starting of complementary foods is delayed and even, if introduced, is often insufficient in nutrients. Only 46% of the infants receive solid food at nine months of age (NFHS II) against the Tenth Plan goal of 75% coverage.

Poor nutritional status is a potent risk factor increasing the neonatal, infant and child mortality. The nutritional status of children in India continues to be a cause for serious concern. According to NFHS II, 47% children under three years of age were below –2 SD weight-for-age (undernourished) and 45% were below -2SD height-for-age (stunted). Over one-third of all infants are born with low birth weight (<2.5 Kg). Child nutrition is also on the agenda of the National Nutrition Mission.

The promotion of exclusive breastfeeding and the introduction of appropriate complementary feeding will, therefore, be a major thrust area in RCH Phase II, in partnership with DWCD.

1.4.2.11 Integrated Management of Neonatal and Childhood Illness (IMNCI)

IMNCI is the Indian adaptation of the WHO-UNICEF generic IMCI (Integrated Management of Childhood Illness)

- The generic IMCI (WHO-UNICEF)

The IMCI concept builds on the lessons learned from disease-specific child survival initiatives such as control of diarrheal disease, management of acute respiratory infections and treatment of malaria. Globally, five childhood illnesses, namely, pneumonia, diarrhea, measles, malaria and malnutrition were recognized as the cause of 70% of 11 million under-five child deaths in the mid-nineties. Significantly, many sick children often have more than one of these diseases. Using disease-based algorithms or clinical approaches, providers tend to ignore the less obvious morbidity or overlook the need for counseling (e.g. for complementary feeding). WHO, therefore, embarked on developing a single, integrated and effective approach to managing childhood illness namely, the IMCI.

The IMCI strategy has three components:

1. Improved case management
2. Health system strengthening and
3. Improved household practices.

WHO-UNICEF rolled out the first component in the mid-nineties with the aim of improving the performance of providers, through training and support, at first-level health facilities where children with potentially fatal illnesses are brought. Evidence-based case management guidelines, structured into algorithms were developed. These guidelines relied on the detection of cases based on simple clinical signs without laboratory tests, and offered empirical treatment. The target of IMCI training was with any health worker who saw sick children at the first-level facility in the outpatient setting. A generic training package of 11 days was developed and disseminated. A manual on inpatient care of sick children was developed, but was not generally included in the standard IMCI training programs.

It should be noted with regard to generic IMCI that: it included the age group from seven days to five years, excluding the early neonatal period (namely, 0-6 days); it was targeted to provide care to

children reaching the first level facility, and it was not meant to be used for community-based workers. (ANMs or AWWs, for instance)

- Lessons learned from IMCI implementation in other countries

Recently, two global studies on IMCI, the "Multi-Country Evaluation (MCE)" and the "Analytical Review," addressing IMCI implementation in other counties have become available. MCE was undertaken in Tanzania, Uganda, Peru, Brazil and Bangladesh, and Analytic Review stems from desk reviews, interviews with national and international informants, and an assessment of implementation expenses in Egypt, Kazakhstan, Indonesia, Mali, Peru and Zambia. The box below provides a summary of the findings of the MCE.

Salient findings of the multi-country evaluation of IMCI

IMCI improved the health worker performance.

IMCI introduction in outpatient facilities led to a reduction in the misuse of antibiotics, correct treatment of child illness with antibiotics, more frequent administration of the first dose at the facility, improved efforts by health workers to educate caregivers in home treatment and increased knowledge among mothers about how to administer drugs correctly.

IMCI did not change key family practices.

Family behaviors such as care seeking and exclusive breastfeeding did not improve.

Health system constraints severely limited the potential impact of IMCI.

The constraints included infrequent supervision, staff turnover, low morale of health workers, conflict between IMCI requirements and previously existing regulations, difficulties in scaling up and low utilization of government health service.

IMCI implementation was not associated with higher costs than the routine care.

Cost per child of caring for under-fives in IMCI districts was lower than in the comparison district.

IMCI implementation did not improve inequities in care seeking, and access to health services and hospitalizations.

The proportion of poor children availing of health services in IMCI areas was no better than that in non-IMCI districts.

Implementation of health systems and community components lagged behind the training activities.

It limited the depth of the programs and led to lack of improvements in family behaviors.

The *analytic review* of IMCI showed that IMCI coverage was low in countries due to lack of financial and human resources and none of the countries implemented the three components of IMCI (training, health systems and community) in an integrated manner. These important lessons were kept in view while designing RCH Phase II in India.

References:

WHO. Geneva. Integrated Management of Childhood Illness: A WHO/UNICEF initiative. Bulletin WHO Supplement 1 to volume 75, 1997.

WHO. Geneva. Multi-country evaluation of IMCI effectiveness, cost and impact. WHO/FCH/CAH/03.5/ (2003)

Analytic review of IMCI. Presentation at Venice meeting of child survival group (January 2004).

IMNCI country adaptation and implementation so far

India is in the early stage of implementation of this strategy. The adaptation committee appointed by the Government of India completed the task of finalizing the plan for the country in 2003. The most significant modification is the inclusion of the 0-6 day of age period. In view of the pivotal emphasis on the newborn, the Indian version of IMCI is named the *Integrated Management of Neonatal and Childhood Illness* (IMNCI). The IMNCI technical guidelines and training modules developed in India are unique in many ways (Table 1.18).

Table 1.18: Differences Between Generic IMCI and India IMNCI

Features	Generic IMCI	India IMNCI
Coverage of 0-6 days (early newborn period)	No	Yes
Basic health worker module	No	Yes
Home visit module by provider for care of newborn and young infant	No	Yes
Training		
Home-based training	No	Yes
Training days for newborn and young infant	2 of total 11 days	4 of total 8 days
Sequence of training	First, the child (2mo. – 5yr); then young infant (7 days – 2mo.)	First, the newborn and young infant (0-2mo.); then, child (2mo. – 5yr)

The chart book and facilitators guide have been revised for use in India. A unique feature of IMNCI is the provision of home visits by the provider for preventive, promotive and referral/curative services for newborns. A module on home-based training has also been developed.

The training period has been reduced from 11 days in the generic version to eight days in the India module. The India IMNCI protocol has also been adapted for the health workers, namely, ANMs, and AWWs. This module is relatively simple and needs translation into local language prior to use.

The IMNCI training package is being introduced in the UNICEF sponsored Border District Cluster Strategy (BDCS) in six districts. This is the first application of IMNCI in the program setting.

1.4.3 Newborn and child health strategy in RCH Phase II

In RCH Phase II, a comprehensive newborn and child health package of interventions will be implemented in the country with the aim of achieving a decisive breakthrough in neonatal, infant and child mortality. The knowledge about what saves the lives of children in a cost-effective manner is available to the nation and the world at large. The mission of RCH Phase II is to translate this knowledge into action and usher in the second child survival revolution in the country.

1.4.3.1 Guiding principles

The following principles will govern the planning and implementation of newborn and child health strategies:

- Evidence-based interventions
- Integrated approach in sync with family planning and maternal health components of the program
- Equity-driven implementation and monitoring
- Rational mix of family-centered (home level), population centered (outreach) and individual-centered (clinical) interventions
- Decentralized priority setting and phasing at the state and district levels
- Participation from the private sector

1.4.3.2 Newborn and child health strategy: The IMNCI 'Plus'

The objectives of the newborn and child health strategy are:

1. Increase coverage of skilled care at birth for newborns in conjunction with maternal care
2. Implement, by 2010, a newborn and child health package of preventive, promotive and curative interventions using a comprehensive IMNCI approach
   - 2.1 At the level of **all**
     - Sub-centers
     - Primary health centers
     - Community health centers
     - First referral units
   - 2.2 At the household level in rural and poor periurban settings in at least 125 districts (through AWWs / LVs / ASHAs)
3. Implement the medium-term strategic plan for the UIP (Universal Immunization Program)
4. Strengthen and augment existing services in areas where IMNCI is yet to be implemented.

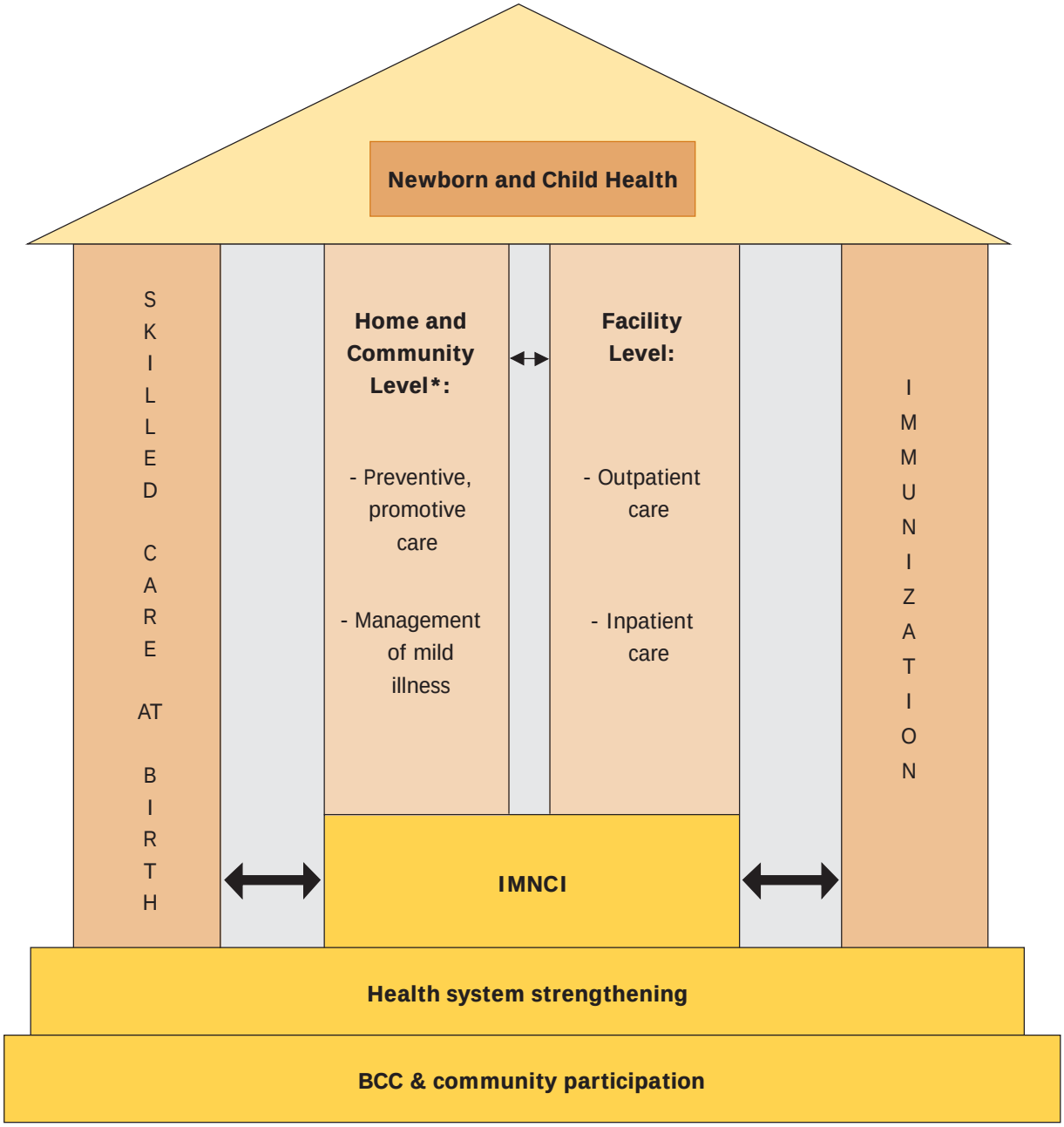
Figure 1.10 depicts the model of newborn and child health strategy in RCH. It has three sets of complementary approaches:

1. Skilled care at birth
2. IMNCI
3. Immunization

1.4.3.3 Why IMNCI 'Plus'

IMNCI, which has been adapted and is under early implementation in India, takes the generic IMCI approach much further by including 0-6 days of age group, by having a health worker module, and by incorporating the home-based approach for newborn care. Yet, there is a need to add the inpatient care component for facilities to ensure effective care of sick neonates and children who require hospitalization.

Fig. 1.10: RCH Phase II - Newborn and Child Health Package



*Also linked to post-partum care of the mothers (This will include: complication detection and management; and counseling on nutrition and spacing)

This will be done by adapting WHO and local guidelines and tools. Even in this comprehensive form, the IMNCI package would still not cover the vital care of the neonates at birth in home and facility settings. Further, the IMNCI approach includes counseling for immunization, but the implementation of immunization in India is largely a periodic outreach activity that cannot be adequately captured by the IMNCI contacts alone. Therefore, a comprehensive immunization plan will be an additional pillar of the newborn and child health strategy. Health system inputs and community level activities are germane to the effectiveness of not only IMNCI, but also that of care at birth, as well as successful immunization strategies.

It is in the light of the above reasons that the newborn and child health strategy for RCH, is named as **'The IMNCI Plus'** to connote the wider, comprehensive range of interlinked interventions that form the newborn and child health component of the RCH Phase II program.

1.4.3.4 Skilled care at birth

This component is linked intimately to the program's maternal care intervention, and thereby a continuum of antenatal and intrapartum interventions.

The underlying principle of effective care at birth is that wherever an infant is born, home or facility, he/she is provided clean care, warmth, resuscitation, and exclusive breastfeeding. He/she is weighed and examined, and if the clinical needs are not manageable at the place of delivery, he/she is referred and managed at an appropriate facility. The RCH Phase II program aims at promoting institutional deliveries. Newborn care is relatively easy to implement in facilities because of the presence of skilled birth attendants (doctor/ nurse/ ANM/LHV), and an enabling/supporting environment. However, a large proportion of deliveries would continue to occur at homes by the TBAs for some more years to come, especially in the EAG states. It is therefore, considered desirable to continue to impart newborn care skills to TBAs in areas with high rates of home deliveries. This should be done in order to enable them to contribute, as much as possible, towards newborn survival and health improvement in partnership with the community members, families and the AWWs/ ANMs/LVs. They will also be provided clean delivery kits. At the same time, the overall effort would be to promote childbirth by skilled birth attendants and in institutions, both in the public and private sector. (Table 1.19)

Table 1.19: Skilled Care at Birth Everywhere

Level	Provider	Key input
Institutions* 24 hour functioning PHCs / CHCs	MOs, ANMs, LHVs, nurses	Delivery room Resuscitation equipment Newborn Care Corner/Unit
FRUs, District hospitals	MOs, specialists, nurses	Maternity OT & delivery room Resuscitation equipment Newborn Care Corner/Unit
Home *(wherever institutional deliveries not possible)*	*Skilled birth attendants* ANMs, nurse practitioners, Community-SBAs	Clean delivery kit Resuscitation equipment
	Trained TBAs (if access to skilled attendants is not possible)	Clean delivery kit

* Private institutions should have the same or better norms

1.4.3.5 IMNCI

The IMNCI approach will be the centerpiece of newborn and child health strategy in RCH Phase II. A comprehensive model of IMNCI will be implemented. It would include the home and community-based component (through ANMs and AWWs/LVs) and the facility-based outpatient care component, as is being piloted in UNICEF's border district project. In addition, a component on management of sick neonates and children in the inpatient setting at PHCs/ CHCs/ FRUs, and in private facilities will be added. Health system strengthening and community participation components will be addressed effectively to ensure effective implementation.

Table 1.20: IMNCI Implementation at Different Levels

Level	Approach	Sites / strategy	IMNCI module	Provider(s)	Key inputs
Home and Community	Home-based newborn care	Home visits on day 1,2, 7,14 & 28; more visits for LBW and sick babies	Basic Health Worker (AWW/LV) module	AWW/ LV/ ASHA supervised by ANM and assisted by TBA	IMNCI medications Referral funds
	Community management of newborn and childhood illness	Neonates and children brought to AWW or sub-center; and those seen at field/home visits and at immunization sessions	Basic Health Worker (ANM) module	AWW / LV ANM	IMNCI drugs as per norms Referral funds
Facility*	Outpatient care at PHCs, CHCs, FRUs, DHs	Outpatient care of neonates and children reporting with illness	Physicians' module	MO; ANM , LV, nurses under supervision	IMNCI drugs Educational materials Observation area Referral transport
	Inpatient care at 24-hour functioning PHCs, CHCs, FRUs, DHs	Inpatient care of sick neonates and children	Care of sick neonates and children**	MO with nurses/ ANMs/ LHVs	Newborn care corner/unit Inpatient area for sick children Requisite drugs and supplies Referral transport

* To be replicated also at private facilities of corresponding levels

** Module to be adapted/developed

It is emphasized that the above strategies will be built on the existing skills of the care providers, and the existing structures and systems. Several activities and approaches of RCH Phase I would be continued with enhanced quality and coverage. There will, however, be significant additions to encompass unattended interventions such as home-based newborn care.

The proposed phasing for IMNCI's coverage is shown in the Table 1.21.

Table 1.21: Cumulative Operationalization of IMNCI (Suggestive)

Level	Providers	By 2006	By 2007	By 2008	By 2009	By 2010
Sub-centers	ANMs	10%	30%	50%	75%	100%
PHCs/ CHCs / FRUs	MOs LHVs	10%	30%	50%	75%	100%
Village	AWW LV ASHA	12 districts	38 districts	62 districts	94 districts	125 districts

1.4.3.6 Training for IMNCI

Training load

The tentative number of providers at different levels to be trained is shown in Table 1.22.

Table 1.22: Training for IMNCI: Levels and providers to be targeted (2005-2010)

Level	Providers	
	Cadre	Number (approx.)
Health System		
All Sub-centers	ANMs	1,30,000
All PHCs	MOs	30,000
All FRUs	MOs	
50% PHCs / all FRUs	Nurses	To be determined
ICDS System		
Villages in 125 districts	AWWs	1,25,000
Private Sector		
Small towns and villages	Private physicians	To be determined in consultation with states and professional bodies.

In-service training

As far as possible, the training of different providers will be done in such a manner that a district simultaneously develops a team at all levels. This would ensure simultaneous operationalization of the entire district health and ICDS system.

A core group is developing the RCH Phase II training work plan. The available training materials and modules are being reviewed. The above outline including the duration of courses is suggestive, and would be finalized by this group. There will be an overarching organization/group/ institution to ensure that the quality of training is ensured for all cadres. The guidelines for this and other organizational issues are being developed.

Pre-service training

The IMNCI Plus training packages as outlined above for different categories of workers will be incorporated into the pre-service curricula of physicians, nurses, ANMs, LHVs, community skilled birth attendants, AWWs and link volunteers after suitable adaptations. The experience gained from the ongoing WHO project on IMNCI in the MBBS curriculum in five medical colleges will be built on while planning this initiative.

Lactation and feeding counseling is also an important area for skills strengthening among all cadres of health workers/professionals.

The Common Minimum Program calls for expansion of ICDS through out the country. It is a unique opportunity to train all the new AWWs in the IMNCI skills as a part of the pre-service training. Likewise, many new ANMs will be trained and deployed in many states. Hence, IMNCI should become a part of the national ANM curriculum.

Table 1.23: In-service training for IMNCI and Skilled Care at Birth

Provider	Content & duration (tentative)	Key input
Health system		
ANMs/LHVs	IMNCI* (8 days)	IMNCI training network/NIHFW network Involve medical and nursing colleges
Nurses	Care of inborn neonates Lactation skills Outpatient and inpatient care of sick neonates and children (6 days)	Medical and nursing colleges/NNF/ TNAI (AIIMS module on neonatal nursing recommended, combine it with inputs on nursing care of the sick child as well.)
MOs	IMNCI and inpatient care of sick neonates newborn resuscitation Inpatient care of sick children Lactation/IYCF skills (8+1+1+1=11 days)	IMNCI training network (to be established) involving medical colleges NNF district training system program with improvements (add sick child care to existing module)
ICDS system		
AWWs	IMNCI*, lactation and young infant feeding counseling (8 days)	ICDS/NIPCCD network
Private sector		
Private physicians	As for the MO	IGNOU (distance education)
TBAs		
TBAs	Clean and safe delivery, home care of neonates including care at birth, breast feeding, warmth, small baby care, detection of danger signs (3 days)	NGOs/district centers

* Will include post-partum care of mothers

1.4.3.7 Health System Issues

Strengthening facilities for care of newborn infants and children

All PHCs will provide the outpatient IMNCI. A minimum of 50% of PHCs countrywide (that are being developed into 24 hour delivery institutions) will provide, additionally: (i) care of inborn neonates, (ii) inpatient care of sick neonates brought from outside, and (iii) inpatient care of sick infants and children. Suitable norms, standards and guidelines will be developed, and integrated with those for reproductive and maternal health services at this level. The norms for the facilities will pertain to: infrastructure, equipment, human resources, drugs/ supplies, referral system, etc.

CHCs and FRUs will be strengthened.

Draft guidelines for newborn and child health services at the CHCs/FRUs have been developed along with those for reproductive and maternal health services. Based on these norms, 2000 FRUs will be operationalized for providing integrated maternal, child and family planning services in RCH Phase II.

A system of certifying and monitoring the operationlization of facilities will be implemented. While operationalizing the facilities, geographical equity will be borne in mind, to ensure that underserved areas get adequate coverage.

1.4.3.8 Ensuring referral of sick neonates and children

Referral funds made available with AWW/ANM would be utilized for the transport of sick neonates and children. PHCs, CHCs and FRUs will have ambulances (outsourced or otherwise) to cater to the referral transport of sick neonates and children. Communities would be educated about the availability of referral funds/ transport, and BPL/SC/ST families in particular would be encouraged to avail of these resources. Community based organizations (PRIs, women's groups, youth groups etc.) will be mobilized to innovate local solutions and mechanisms to ensure transportation of sick neonates and children.

1.4.3.9 Permitting ANMs and AWWs to administer selected antibiotics

To ensure that the life-threatening conditions of sick neonates and children are managed quickly and effectively, it is of fundamental importance that the providers closest to the communities have the necessary skills and the mandate to mange these killer diseases. This is particularly critical for the poorest who cannot seek care away from their homes due to lack of resources.

At present ANMs cannot manage newborn babies with sepsis, because they are not permitted to administer gentamicin injections. Also AWWs cannot treat diarrhea or pneumonia with ORS and cotrimoxazole. Therefore, it is necessary to examine whether:

- ANMs can be permitted to administer gentamicin injections to neonates. The same would apply to community-SBAs.
- AWWs can be permitted to administer ORS and cotrimoxazole as per the IMNCI algorithms. This strategy would go a long way in improving access of critically sick neonates and children to treatment, especially those from the poorest families.

Skills-based training and supportive supervision will be instituted to ensure acquisition and retention of skills by the workers, to administer the specified drugs. Injection safety norms will be followed strictly for gentamicin injections. Disposable or AD syringes will be provided.

1.4.3.10 Other health system issues

The strength and efficiency of the following elements of the health system in addition to those covered above will determine the success of IMNCI Plus strategy. Deployment of providers with the desired motivation, commitment and competence to do the following:

- Strengthening of health infrastructure
- Uninterrupted availability of drugs and supplies
- High quality supervision and monitoring
- Ownership of the state and district level program managers
- Efficiency of the administrative/ financial system

These are crosscutting issues and are equally important for other domains of the RCH program. Recognizing this, RCH Phase II plans to incorporate an unprecedented emphasis on institutional reforms to rectify the health system weaknesses that have plagued the program.

Strengthening neonatal care services and education infrastructure at medical/ nursing teaching institutions.

Newborn services are often inadequately developed at government teaching institutions. This hampers training of the medical/nursing students, and limits the potential of these institutions to play the desired range or role in training, research and referral care in the program. Therefore, it is proposed to strengthen newborn and child health services of medical colleges. Likewise, nursing and ANM schools will be strengthened to improve their training expertise, capacity and quality.

1.4.3.11 Community-based interventions

BCC and community mobilization are crosscutting areas in RCH Phase II. Inputs for ensuring effective demand for and utilization of services for newborn and child health gains will be systematically woven into the overall BCC and community mobilization strategy.

The following is the outline of the **key themes** that would be promoted through all possible channels and mechanisms.

- *Mobilize families for institutional deliveries in government/ private_facilities* - Launch a sustained social mobilization effort with the help of PRIs, opinion leaders, NGOs, self help groups and other stakeholders; mobilize communities for Janani Suraksha Yojana.
- *Promote healthy home care practices for newborn care* - Promote warmth, early and exclusive breastfeeding, cord care and hygiene; avoid harmful practices including early bathing, colostrum discarding, pre-lacteals and cord applications etc.
- *Promote healthy home practices in diarrhea* - Educate families and communities in the use of home fluids, continuing breastfeeding and solid feeds in diarrhea, early introduction of ORS to prevent dehydration.
- *Make ORS readily/ freely available* - Make ORS packets available with all primary care providers (AWWs, ANMs, male workers, link volunteers, teachers etc.) and at all anganwadis, sub centers and health facilities (PHCs, FRUs, CHCs, hospital); use alternative approaches for making ORS readily available (public distribution system, social marketing, etc.).
- *Widen the net of persons who can treat diarrhea* - Involve male workers, community volunteers and village practitioners among others to treat diarrhea with ORS.
- *Promote early recognition of neonatal and childhood illness* - Educate, families regarding the signs of sickness ('danger signs') among neonates and children, enable families to seek care early from trained providers.
- *Improve referral of sick neonates and children who cannot be managed at home* - Educate families, facilitate transport, and make referral funds available with AWWs and ANMs, focusing particularly on BPL/SC/ST families.

1.4.3.12 Other strategies

- Promote the use of the more effective low osmolarity ORS as recommended by WHO
- Ensure 100 % registration of births as envisaged in the National Population Policy (2000)

1.4.3.13 Newborn and child health in urban areas

The principles of newborn and child health services in urban areas would be the same as outlined above. Because of the unique features of the urban setting and the multiplicity of the actors and agencies, adaptation of the above approaches would be necessary. While developing the urban RCH component, the states are being encouraged to build on the existing systems to plan most suitable delivery models to take interventions to the poorest neonates and children.

1.4.3.14 Promoting care for sick neonates and children of BPL families in the private sector

Private-public participation is being addressed in the RCH Phase II design. Options and mechanisms are being examined to explore how BPL families can access life-saving care for obstetric or pediatric emergencies in the private sector. States are being encouraged to develop innovative approaches towards this objective. The issues of quality standards and accreditation of facilities that would be compensated from public funds in lieu of care provided to BPL mothers/children are also being examined.

1.4.3.15 Operations research

- Develop a system to monitor the cause-specific burden of neonatal and childhood mortality.
- Develop models of primary care newborn service delivery for rural and periurban settings.
- Assess the role of micronutrient supplementation in reducing morbidity and mortality among LBW neonates.
- Track the burden of low birth weight neonates and their epidemiology thereof.
- Undertake surveillance of pneumonia and dysentery-causing bacteria and their antimicrobial sensitivity.
- Access effectiveness of Rotavirus, H. influenzae and Pneumococcal vaccines.

Work in progress

The Ministry is currently engaged in developing the Child Health Strategy for RCH Phase II based on the PIP. A detailed operational plan will be developed especially on scaling up of IMNCI. The strategy will also address the issue of strengthening the existing child health interventions in areas where IMNCI is not likely to be implemented during the course of RCH Phase II. Alternative approaches to improving newborn health services in these areas are being examined.

1.4.3.16 Infant and Young Child Feeding (IYCF)

Child nutrition is a wide and cross-sectoral issue. The RCH Phase II program activities will complement activities of ICDS and other departments in regard to the promotion of breastfeeding and appropriate complementary feeding practices.

Interventions on IYCF will be spread all over the country.

Objective

The objective of RCH Phase II strategy on IYCF will be to contribute towards the attainment of the national goals in nutrition in partnership with the Department of Women and Child Development and other departments.

National guidelines of infant and young child feeding developed by DWCD will be implemented.

A "National Breastfeeding Partnership" has been announced recently in recognition of the importance of breastfeeding as the crucial child survival intervention.

The following strategies will be implemented.

- *Implement a nation-wide behavior change effort to promote breastfeeding.* By involving all grassroots workers viz. TBAs, AWWs, ANMs, village practitioners, male workers, link volunteers etc.; panchayats, self help groups, agents of change, opinion leaders, NGOs; employing mass media; using all health-related contacts to promote improved breastfeeding; standard unambiguous messages need to be given (i.e. 'exclusive breastfeeding for **six** months').
- *Augment AWW's contacts with mothers*. Promote home visits by AWWs in the antenatal and post-natal periods as a part of IMNCI Plus activities.
- *Use all ANM / male health worker contacts for IYCF counseling.* Use immunization sessions, field visits of ANMs and male health workers for IYCF counseling.
- *Strengthen breastfeeding promotion efforts at facilities.* Promote ten steps for successful breastfeeding at various healthcare facilities including PHCs, CHCs, FRUs and district hospitals.
- *Improve IYCF counseling skills of providers.* Train TBAs, AWWs, ANMs, LHVs, male workers, link volunteers, as well as physicians (government, private; general, specialist; modern, ISM) and nurses in lactation and feeding counseling techniques through pre-service and in-service training and education.
- *Implement the IMS (infant milk substitutes, feeding bottles and infant food: regulation, supply and distribution). Act*. Implement it more effectively by educating providers at all levels about the key provisions of the Act.
- *Promote appropriate and adequate complementary feeding.* Strengthen the AWW's role through supportive supervision and monitoring, use all health related contacts to counsel mothers about solid foods; emphasize portion size and calorie density; promote culturally acceptable, low cost, balanced and locally available infant foods (prepare local lists for counseling).
- *Launch a "National Breastfeeding Partnership" with a clear mandate, resources, networking mechanisms and roadmap.* The aim is to bring all stakeholders together to raise the profile of this key agenda in the country and, not only converge their own programs, but to jointly run a sustained high profile breastfeeding movement in the country.

1.4.3.17 Vitamin A, Iron and Folic Acid supplementation

Recommendations on this component are being developed by the DoH&FW through a consultative process.

1.4.3.18 The UIP Multi-year Strategic Plan

This medium term plan addresses the geographic and social inequities in immunization coverage rates. It aims to increase awareness of all stakeholders about immunization strengthening and strengthening management roles at each of the three specific levels; center, state/union territory and district. The plan aims to strengthen the immunization infrastructure within the broader RCH program as well as inter-sectoral linkages.

Medium term goals and strategies

The medium term plan envisions six goals, each with its own set of objectives and strategies. The six goals and their respective objectives with strategies to achieve these objectives are summarized below.

Goal 1: Districts will provide efficient and safe immunization services to all infants and pregnant women

To achieve this goal the following objectives have been planned.

Objectives

- To ensure regular immunization sessions are planned and held.
- To ensure adequate trained staff are empowered to provide essential quality immunization services.
- To keep an annually upgraded inventory of the cold chain, according to the different levels of the network, allowing for new equipment, substitution, replacement, spare parts, fuel and other expenditure in order to maintain a functional status of 90%.
- To ensure efficient vaccine and injection equipment management and a logistics system to forecast and deliver an adequate supply of vaccines in a timely manner.
- To ensure the implementation of safe injection practices and waste disposal

To achieve the above objectives the following strategies will be adopted.

Strategies

Coordination between national and state level; printing and supply of national operation guidelines; strengthening of supervision; prioritization of poorly performing districts; prioritization of under served populations within districts; proper micro planning, filling up of vacancies; strengthen training for all categories of staff; assessment of the cold chain, procurement and installation of cold chain equipment, proper inventory management, cold chain maintenance and repairs; timely supply of vaccine, ensuring quality control of vaccines; phased introduction of AD syringes and safety boxes.

Goal 2: Contribute to global polio eradication, measles mortality reduction and neonatal tetanus elimination

Objectives

- To achieve polio eradication certification by 2007.
- To eliminate neonatal tetanus (NNT) by 2009.
- To reduce measles mortality by two-thirds by 2010, compared to 2000 estimates.
- To achieve and maintain a level of 70% coverage with two doses of Vitamin A supplementation to children below three years of age.

Strategies

Routine immunization for polio, supplementary immunization campaigns, AFP virological surveillance, strengthen service delivery, increase reporting and action on cases, data analysis, safe delivery practices, targeted SIAs, strengthening measles surveillance and outbreak response

Goal 3: The UIP will have sufficient and sustainable funding with established adequate, accountable and efficient fund flows

Objectives

- To ensure adequate and reliable financial resources at national, state and local levels for the UIP to achieve its goals and objectives.
- To ensure political commitment for adequate annual funding, at all levels.

Strategies

Strengthening of National financial planning, partnership building (strengthening ICC).

Goal 4: Sustain demand and reduced social barriers to access immunization services

Objectives

- To ensure widespread support by all families and communities and to ensure that all eligible children and pregnant women are immunized.
- To ensure high-level political and administrative support for immunization as an important public good.

Strategies

Coverage with print, electronic media and other mass media, improve interpersonal communication.

Goal 5: Accelerated introduction of licensed new and under utilized vaccines against diseases with significant mortality and morbidity in India

Objectives

- To ensure that institutional mechanisms are in place to adequately obtain, review and utilize information for deciding on the introduction of new and under utilized vaccines.
- To review the need for MMR or MR vaccine in India's immunization program.
- To review the need for the introduction of Japanese encephalitis (JE) vaccine in selected states.
- To implement a phased introduction of Hepatitis B vaccine.

Strategies

Improve coordination between the MoH&FW, research institutes, NRIs and development partners, disease burden study, surveillance, and training.

Goal 6: To monitor and use accurate, complete and timely data on vaccine preventable diseases, AEFIs, antigen coverage and drop out rates by the district

Objective

- To institutionalize surveillance for vaccine-preventable diseases and early detection of any outbreaks.
- To strengthen vaccine quality and injection safety by developing a monitoring system for reporting and responding to adverse events following immunization (AEFI) by 2009.
- To establish an effective, efficient, complete and timely immunization recording and local area monitoring system by 2009.

Strategies

Introduction of a software database system; increase accuracy and the use of data at local levels; private sector and community involvement; laboratory confirmation and strengthened linkages with surveillance, AEFI, NRA; strengthen the monitoring system at the local level; decentralization of monitoring to strengthen local use of information for action; use of data at different levels; use of surveys and linkages with private sector.

Managing the Universal Immunization Program under the MYP

To implement this MYP plan will require strengthening of the management system at the national level.

The areas that would need strengthening are:

- Vaccine, cold chain and logistics
- Program implementation
- Administration unit
- Monitoring and evaluation
- Surveillance
- Immunization training
- Strategic communication
- Procurement unit
- Operational research
- Financial unit

Existing structure of central management of UIP

Program Implementation

Staffing: An officer of the rank of Deputy Commissioner/DDG will be the overall officer responsible for the immunization program and is also the technical head of the program. S/he will be assisted by Assistant Commissioners/Deputy Secretary and other support staff

Program Implementation Unit

Staffing: An officer of the rank of Assistant Commissioner will be the person responsible for the implementation of the immunization program. He will assist the Deputy Commissioner/DDG in the formulation of national immunization policies to be adopted at the state /district level, hold regular review meeting with states and categorize the state in terms of performance and give attention to each category.

Responsibilities

- Develop, disseminate and institute national immunization policies, adaptable at state level.
- Develop, disseminate and institute multi year national immunization plans to assist states on a priority basis.
- Set national priorities, standards and coordination mechanisms of tetanus campaigns and measles mortality reduction initiatives according to priority reviews with polio eradication.

Vaccine, cold chain and immunization supply logistics unit

Staffing: An officer of the rank of Assistant Commissioner has the overall responsibility for vaccine and cold chain logistics.

Responsibilities

- Vaccine forecasting, reconciliation of stock balance at the end of each financial year.
- Vaccine supply and quality, immunization safety and waste disposal
- Vaccine tracking through out the year.
- Ensuring the timely procurement of quality vaccine for UIP and cold chain equipment and their distribution to the states.
- Ensure necessary vaccines and supplies are distributed, according to need, to state regional store level.
- In combination with the NRA, ensure the quality of vaccines, injection equipment, cold chain equipment and waste disposal materials that are purchased for the UIP.
- Ensure that adequate AD syringes, safety boxes and disposal methods are provided and distributed down to the block level. These will be distributed according to the multi year plan and immunization safety policy.

Administration Unit

Staffing: This is headed by an officer of the rank of Deputy Secretary, who assists the DC/DDG in day-to-day affairs.

Responsibilities

- General administration
- Program specific administration
- Parliamentary matters
- Audit (jointly with finance unit)

- VIP references
- Legal issues pertaining to immunization

Units proposed to be strengthened at national level

Training unit (supported by NIHFW)

Staffing: A technical officer will be responsible for the training in coordination with NIHFW.

Responsibilities

- Preparation of standard quality operational guidelines and training modules.
- Implementation of standardized training (in consultation with nodal agencies).
- Devise and disseminate standard quality operational guidelines, down to all immunization providers in India.
- Devise and disseminate standard quality training material throughout the country for use by state training institutions.
- Advise on frequency of training and refresher training.
- Ensure that there are a sufficient number of trained state and district immunization officers.

Note : *Technical training for cold chain handlers and mechanics will not be provided by this unit*

Monitoring and Surveillance Unit (supported by WHO / NPSP)

Staffing: The unit will be headed by a system analyst having knowledge of computer programming. She/he will be responsible for the compilation and analysis of data and feedback to the program officer.

Responsibilities

- Devise and disseminate (down to the block level) standard quality immunization monitoring tools (child and mother immunization cards, immunization registers, monitoring charts, tally sheets, ticker box systems and monthly immunization reporting forms).
- Devise and ensure the use of a standard mechanism for monitoring the UIP at all immunization provider sites. This would include immunization coverage rates, drop out rates, sessions planned and held, vaccine availability and distribution, service quality indicators and cold chain availability and functioning.
- Devise and disseminate a VPD surveillance overview.
- Provide trained staff and systems to monitor and respond to reported AEFIs (including periodical publications on AEFIs).
- Provide technical assistance to states to set up AEFI monitoring systems

Strategic communication unit (supported by UNICEF)

Staffing: The unit will be headed by a person with qualification in mass communication who will formulate the IEC strategies for the program. She/he will also coordinate with the states' program.

Responsibilities

- Provide and distribute standard quality national IEC materials for routine immunization to be provided down to the block level.
- Ensure high-level political support for immunization activities.

Research and development unit (supported by ICMR)

Staffing: A technical officer will be responsible for coordination of all the research and development activities in coordination with ICMR and other development partners.

Responsibilities

- Encourage institutions to increase appropriate research in immunization issues.
- Ensure research results are disseminated and shared widely for policy-making decisions.
- Outsource necessary immunization research elements of national interest.

Proposed new units

Procurement Unit

Staffing: This unit will be headed by a person qualified in management/logistics

Responsibilities

- Completing all processes required for the procurement of vaccines, cold chain equipment and other logistics required under the immunization program.
- Ensure proper distribution, tracking, reflection in adjustment sanction etc.
- Coordination with procurement division/agency.

Cold Chain Maintenance Unit

Staffing: This unit will be headed by an engineer, qualified in refrigeration.

Responsibilities:

- Ensure that adequate cold chain equipment is provided and distributed according to the MYP prepared down to the state level.
- Inventory management of spare parts.
- Supply to states.
- Monitoring the functioning of cold chain equipment.
- Release of funds for cold chain maintenance.
- Replacement of CFC equipment by CFC free equipment etc.
- Training cold chain handlers and mechanics.

Finance Unit

Staffing: A qualified CA (Chartered Accountant) or Cost Accountant will head this unit.

Responsibilities

- Resource mobilization coordination and overall finance related matters.
- Provide financial information for planning (including adjustment sanctions, release of funds).
- Liaison with ICC members on financial issues.
- Overview of estimated resource requirements, budgeting and expenditure control.
- Audits

Linkages

States

The Center will closely collaborate with state governments and state immunization officers through the following ways.

- Technical advice
- Regular meetings of state immunization officers.

International agencies

Donors and development partners will meet regularly with the "National Program Authority" for ICCs and coordination in all other fields.

NTAGI (National Technical Advisory Group on Immunization)

The NTAGI will meet on a regular basis with the Center for technical consultation.

MoH&FW

The program will be administratively under the Department of Family Welfare.

NGOs and private practitioners

State/district level authorities will coordinate and provide support to private practitioners and NGOs.

1.4.3.19 Role of different health care providers for newborn and child health services and alternatives at the grassroots level

Table 1.24 summarizes the role of different functionaries for the IMNCI plus strategy on RCH Phase II.

Alternative providers at the grassroots rural and urban slum level

In order to save sick mothers, neonates and children, it should be possible to reach a provider within half an hour in an emergency. Therefore, each village and each medium-sized urban settlement requires a competent provider. An AWW can serve this role as she has been inculcated in the above chapters. However, many areas do not have the ICDS system. Also, AWWs, being tuned to a different set of training and tasks, may have limitations in performing many of the RCH activities despite sincere intentions. It is therefore suggested that states may consider alternative workers to take on a role in RCH Phase II implementation. These approaches need to be carefully developed, evaluated and scaled up. Some suggestions for consideration include:

- *Franchising ANMs* - ANMs after pre-service training be allowed to practice in their area.
- *Nurse Practitioners* - Nurses after pre-service training be allowed to practice.
- *RCH Link Volunteer* - Guidelines for this are being developed by the DoH&FW.
- *Community-Skilled Birth Attendant (C-SBA)* - The scheme is being piloted.
- *Registered Medical Practitioners.* These individuals do not have formal qualifications, but provide curative services in villages. Together, they form a part of the private sector in rural and even poor urban areas. They are, however, not accepted as health workers or health professionals. RMPs have been involved in some NGO programs for selected activities. There may be some scope for a more formal role in RCH Phase II that the states may like to consider.

Table 1.24: Role of Different Health Care Providers in Newborn and Child Health in RCH Phase II

Providers	Care at birth	IMNCI		Immunization
		Home & community	Facility	
Health system				
ANM	Attends deliveries at sub-center/home	■ Supervises AWWs; ■ Visits LBW and sick neonates at homes; ■ Provides care to sick newborns and children	Acts as nurse when posted at PHC	Plays prime role
LHV	Attends deliveries at PHC	Supervises ANMs	Supports care of admitted neonates/ children	Supervises ANMs
MO	Attends deliveries at PHC/CHC/FRU	Supervises LHVs, ANMs, AWWs	■ Provides care to neonates; ■ Provides outpatient and inpatient care to sick neonates and children	Supervises staff
Nurse	Attends deliveries at facility		Provides inpatient care to sick neonates and children	Provides immunization at facility
Village level				
AWW/LV	Promotes institutional deliveries/skilled care at birth	■ Plays key role by making home visits on days 1,2,7,14,28 for all neonates, more visits for LBW or sick neonates ■ Provides selected aspects of care to sick neonates and children ■ Plays more effective role in newborn and child care at AW		Facilitates immunization services
Private sector				
Physician	Attends deliveries at facility		■ Provides outpatient and inpatient care of sick neonates and children ■ Provides care to inborn neonates	

Contd...

Providers	Care at birth	IMNCI		Immunization
		Home & community	Facility	
TBAs				
TBA	■ Takes part in Janani Suraksha Yojana ■ Conducts home deliveries where skilled birth attendant is not available ■ Helps AWW and ANM in care of neonates ■ Assists families in providing care to newborns at home			

1.4.4 Improving infrastructure of teaching institutions for improved role in RCH Phase II

Aim

To improve the infrastructure of 100 government-run teaching institutions to enable them to contribute to the RCH Phase II program more effectively.

Objectives

Strengthen facilities at teaching institutions for providing optimum obstetric, family planning, neonatal and child health services.

Strengthen capacity of teaching institutions for imparting pre- and in-service education and training to providers in reproductive and child health.

Scope

The purpose of this initiative is to supplement the resources available to the government sector teaching institutions to improve the obstetric, family planning, neonatal and child health services and to strengthen the training/education capability of the departments of obstetric and gynecology and pediatrics.

The funds (approximately 50 lakh for each medical college) will be made available under this scheme for development, repair, expansion, improvement and equipping of the existing areas. Since the requirements of the different institutions are likely to be different, the exact extent of infrastructure/equipment strengthening will be individualized.

Funds will be **equally divided** between the departments

- Obstetrics and Gynecology
- Pediatric:

Obstetrics and Gynecology: Labor and delivery room(s), operation theatre(s) (minor/major), maternity wards; teaching room and A-V aids.

Pediatrics: Newborn unit(s), lying-in ward, sick child treatment room(s); diarrhea treatment unit, teaching room and A-V aids.

Resources may also be spent on strengthening referral transport for mothers and children, if deemed a priority.

Detailed guidelines will be developed to implement this scheme in consultation with medical professionals. A sub group has been formed to design the objectives, contents of training, suggested training approach and facility needs in order to strengthen the capacity of the teaching institutions.

1.5 Adolescent Health

1.5.1 Introduction

Adolescents (10-19 years) in India represent almost one-third of the population. A large number of them are out of school, get married early, work in vulnerable situations, are sexually active, and are exposed to peer pressure. These factors have serious social, economic and public health implications. Adolescents are not a homogenous group. Their situation varies by age, sex, marital status, class, region and cultural context. This calls for interventions that are flexible and responsive to their disparate needs.

It is important to influence the health-seeking behavior of adolescents as their situation will be central in determining India's health, mortality and morbidity; and the population growth scenario.

Some of the public health challenges for adolescents include pregnancy, excess risk of maternal and infant mortality, sexually transmitted infections and reproductive tract infections in adolescence, and the rapidly rising incidence of HIV in this age group. In context of the RCH program goals, with special reference to reduction in IMR, MMR and TFR, addressing adolescents in the program framework will yield dividends in terms of delaying the age at marriage, reducing the incidence of teenage pregnancy, the prevention and management of obstetric complications including access to early and safe abortion services and the reduction of unsafe sexual behavior.

The use of services by adolescents is limited. Poor knowledge and a lack of awareness are the main underlying factors. Pregnancy is associated with significantly higher obstetric risks in adolescent girls and yet they are no more likely than older women to obtain antenatal care or experienced institutional or skilled attendance at delivery. Few understand the importance of prompt pregnancy related care.

Studies show that pregnancy in the early teens, before 16 years, is associated with an adverse effect on maternal nutrition, birth weight and survival of the offspring. Many adolescents suffer from malnutrition and anemia. Many may not have received tetanus immunization. Anemia during adolescence can get worse during an ensuing pregnancy. Thus, ill health during adolescence has profound implications for maternal, perinatal, neonatal and infant mortality.

Service provisions for adolescents are influenced by many factors. For example, at the level of the health system, a lack of adequate privacy and confidentiality, and the judgmental attitudes of service providers, who often lack counseling skills, are barriers that limit access to services.

1.5.2 Strategy for addressing Adolescent Reproductive and Sexual Health (ARSH) in RCH Phase II

A two-pronged strategy will be supported. Strategy One falls within the overall scale and coverage of the RCH Phase II program. The DoH&FW will incorporate adolescent issues in all the RCH training programs and all RCH materials developed for communication and behavior change. This will entail that interventions

for addressing unmet need for contraception and pregnancy care, prevention of STIs including HIV/AIDS will have specific activities to reach out to adolescents. Strategy Two will be implemented in select districts. This strategy will require the DoH&FW to undertake special efforts to reorganize services at the PHCs on dedicated days and dedicated timings for adolescents. This will depend on local capacities to deliver, staff availability and orientation.

1.5.3 Policy and institutional framework

Both the National Population Policy 2000 and the Tenth Five Year Plan highlight the need for catering to the reproductive and sexual health needs of the underserved population group such as adolescents. This policy framework will guide the implementation of the operational plan for ASRH service delivery through the existing public health system.

Policy level actions would need to be considered by the DoH&FW to facilitate implementation of the operational plan. These relate to, for example, administrative guidelines for providing contraceptives to unmarried adolescents, consistency and clarity with regard to contraceptive delivery and access to services, the identification of a core package of services for adolescents at all levels of health care. The DFW will need to steer policy dialogue and partnerships with other departments for inter-sectoral activities.

At the district level, the district RCH Society will be responsible for the overall implementation and regular monitoring. The district RCH Officer will be the focal point. Medical and health care needs will be met through the existing network of CHCs, PHCs and sub-centers.

Depending on the presence of the private sector especially in rural areas, private providers can be engaged in the provision of ASRH services. The possibility of engaging private providers for organizing teen clinics on dedicated days/time can be explored. Pediatricians and general practitioners could be engaged through their respective associations for providing free counseling services once a week for the adolescents. Partnerships will also be attempted with members of FOGSI, local chapters of the Indian Academy of Pediatrics, NGOs and other departments and stakeholder groups. Synergy with other health initiatives, in particular, the National AIDS Control Organization, will need to be promoted, especially with school health programs.

1.5.4 Coverage

Any operational model to provide ASRH services of necessity will have to take into cognizance the diversity of the program and maturity of health systems in the states. Hence, the specifics will need to be worked out, while developing state specific plans for RCH Phase II.

On a priority basis, it will be useful to pilot service delivery interventions in selected districts. One of the criteria for selection of districts could be the marriage age for girls and recent RHS data can be used to identify districts where more than 60 % girls marry below the age of 18. It is presumed that in these districts the incidence of teenage pregnancy shall also be high.

1.5.5 Operational framework for ASRH

1.5.5.1 ASRH service delivery through the public health system

A framework is proposed for operationalizing ASRH services within the context of public health systems. Actions are proposed at the levels of the sub-center, PHC, CHC and district hospital for delivering services to adolescents through routine OPDs, and a dedicated time (for example, once a month clinic for addressing the needs of unmarried and newly married adolescent girls).

The matrix below outlines service provision at each level of care.

Level of care	Service provider	Target group	Flow of service delivery activities	Services
Sub-center	HW(F)	Unmarried F Married F Unmarried M Married M	During routine sub-center clinics	■ Enroll newly married couples ■ Provision of spacing methods ■ Routine ANC care and institutional delivery ■ Referrals for early and safe abortion ■ STIs/HIV/AIDs prevention education ■ Nutrition counseling including anemia prevention
Primary Health Center/ Community Health Center	■ Health Assistant (F)/LHV ■ Medical Officer	Unmarried male and female	Once a week, teen clinic will be organized at PHC for 2 hrs	■ Contraceptives ■ Management of menstrual disorders ■ RTI/STI preventive education and management ■ Counseling and services for pregnancy termination ■ Nutritional counseling ■ Counseling for sexual problems

1.5.5.2 Key interventions for operationalizing ASRH

In order to facilitate provision for adolescents, the key interventions are explained below. These include - the orientation of service providers, environment building activities and MIS.

Orientation of service providers

Equipping service providers with knowledge and skills so as to enable them to cater to the reproductive and sexual health needs of adolescents is critical. The core content would include vulnerabilities of adolescents, need for services, and how to make existing services adolescent friendly. Based on the package of services chosen for implementation, these orientations could be modified. A self-learning module for peripheral service providers has been developed by DoH&FW and can be used in the orientation program for service providers.

These orientations would need to be integrated with other RCH Phase II skill development trainings. At the district level the RCH officer would be the nodal person responsible for organizing quality reproductive and sexual health services.

Environment Building Activities

Prevailing social barriers restrain adolescents from using the services. There is need to conduct some environment building activities so as to reach out to a broader range of gatekeepers with appropriate

messages. The key audiences could include district officials, panchayat members, women's groups and civil society.

The communication activities would essentially focus on the vulnerabilities of adolescents, the need for ASRH and a suggested package of services. For each group of stakeholders, communication material will have to be developed in the local language. It is proposed that the DHO/RCHO at the district level and the MO at the block level takes the lead in organizing such communication activities. In each district, the capacity of institutions and NGOs for conducting such communication programs can be assessed.

An intensive national campaign to generate awareness on key adolescent issues could provide an ideal backdrop for the launch of services in pilot districts.

MIS

Current health MIS does not analyze data in terms of adolescents as a separate client group. The revised MIS suggested in RCH Phase II will disaggregate information on key indicators to monitor the coverage of adolescents with preventive and promotive interventions. The main focus will be to monitor the teenage pregnancy rate, institutional delivery and the prevalence of STIs etc.

Evaluation and Operations Research

Adolescent health is a new component of the RCH program. In order to convert this initiative into a sustainable activity, it will be important to carefully monitor and evaluate its implementation. It is important that operational research studies are built into the program to develop new strategies.

1.5.6 Logical Framework

A logical framework for ASRH in RCH Phase II is presented on the next page. It spells out the outcome, outputs, activities and the key indicators and means of verification.

1.6 Initiatives with Respect to Vulnerable Groups Including Urban Disadvantaged and Tribal Population
(Vulnerable communities including SCs/STs)

1.6.1 Background

Vulnerable communities include those groups who are under-served due to problems of geographical access, (even in better off states) and those who suffer from 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. The SCs constitute 16.2% and STs 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. SCs/STs 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: Arunachal Pradesh, Meghalaya, Mizoram, Nagaland, Dadra and Nagar Haveli and Lakshadweep, where more than 60% of the population is tribal and another nine states (Andhra Pradesh, Assam, Jharkhand, Gujarat, Chhattisgarh, Maharashtra, Orissa and West Bengal) where the majority of tribal people live. The scheduled caste population is spread over all the states and UTs. However, in the states of Arunachal Pradesh, Nagaland, Manipur, Mizoram and Goa, the SC population is less than 3%. The RCH indicators for slum population

Logical Framework

Purpose/ Outcomes	Objectives/Outputs Level		Activity/Input level	
	Objectives/ Outputs	OVIs/MOV	Activity/Input	OVIs/MOV
Improved reproductive health status of adolescent girls and boys	To increase utilization of reproductive health services by adolescent and young girls and boys	■ Teenage pregnancy rate ■ Prevalence of RTIs/ STIs ■ Use of condoms during the last sex among age group 15-19 years ■ Incidence of anemia in girls age 15-19 years ■ Mean age at marriage ■ Incidence of anemia among pregnant teenage mothers ■ No. of maternal deaths among teenage mothers ■ Proportion of HIV positives among 10-19 years age group **MOVs for above:** MIS/Rapid HH survey, Rapid survey MIS/PRI reports, Sentinel surveillance reports.	**Increase supportive attitude towards ASRH through:** ■ Orientation of state and district program managers. ■ BCC, communication activities and mass media campaigns.	% knowing benefits of providing adolescent friendly health services. **MOV: Rapid assessment** % of sub-centers having communication material for adolescents. **MOV: Reports of supervisory visits.** Percentage of planned group meetings held **MOV: Sub center/PHC report**
			Increase capacity and skills for providing information and services through: ■ Orientation of service providers. ■ Improving MIS for data collection on ASRH.	% of public providers trained in providing adolescent friendly services **MOV: Training reports**
			Increase provision of ASRH services (including maternal health, RTI/STI management, contraceptives, MTP, and counseling services) through ■ Sub-center ■ PHC	■ No. of newly married couples registered during the month ■ Proportion of teenage pregnant women attending ANCs ■ Proportion of teenage PW delivering in the institutions ■ Proportion of teenage girls availing MTP services ■ Proportion of adolescents seeking RTI services **MOV for above: Sub center/PHC report**

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 as a result of service provider behavior as of health seeking behavior 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 the rest of the population for a number of RCH indicators that are relevant to the MDGs. A comparative statement under different RCH components for SCs and STs against the rest of the population is given in Table 1.25.

Table 1.25: Health Indicators for Scheduled Castes and Scheduled Tribes

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 anemia	78.3	79.8	72.7
% Children with ARI (prev 2/52)	19.6	22.4	18.7
% Children with diarrhea (prev 2/52)	19.8	21.1	19.1
% Women with anemia	56.0	64.9	47.6

1.6.2 Rationale for vulnerable groups reproductive and child health plan under RCH Phase II

1.6.2.1 Demand-side barriers to accessing services

Poor connectivity to health centers because of distance, topography, and lack of public transport;

- Location disadvantage of sub-centers, PHCs, CHCs.
- Social and cultural barriers, especially for women.
- Lack of suitable transport facility for quick referral of emergency cases.

Structural constraints

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

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.

RCH Phase II seeks to address the above concerns proactively. The Vulnerable Groups Health Plan for the RCH Phase II program adds value by acting as a "conscience" within the DoH&FW to ensure that RCH Phase II is progressively more focused on reaching those least served, and by earmarking a separate pool of resources that will enable the implementation of innovative solutions in the following areas: 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.

1.6.2.2 Goals and objectives

Goals: To improve the health status of the 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 the supply of equipment, drugs etc. in an integrated and participatory manner and (ii) to bring them at par in this respect with the 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.

1.6.2.3 Strategy

- In the first year of RCH Phase 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 the 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. The private sector and NGOs will also give priority to vulnerable groups and supplement/complement the efforts of government departments.
- RCH Phase II also has a fund for performance bonus 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 the 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 comprehensively addressing the problem of improving services to the vulnerable. In the later years of the program, output and outcome indicators will be used to show the benefits received by vulnerable groups.

- Consultation and participation: Elected representatives of PRIs at various levels will be involved in the 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. Groups will be formed at the village level (including Gram Pradhan, ANM, AWW, link workers and two members of the Gram Sabha. Similar groups may be formed at the block level and the district level.

1.6.3 Health plan for vulnerable groups

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 the PIP for tribal health. The PIP for tribal health gives details as to how the health plans are to be prepared, the funding pattern, interventions envisaged etc.

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.

A health plan for slum dwellers in urban areas will be prepared in accordance with the PIP for urban slums. Urban slum health proposals are required to be prepared for cities / towns having a population of more than one lakh. The PIP for urban health incorporates guidelines for the preparation of urban slums health projects, funding pattern, interventions envisaged etc. In smaller towns, the requisite focused interventions for the urban poor including slum dwellers will be incorporated in the district plan.

The health plan for other vulnerable groups 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 groups 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.

Work plan

State governments will designate a Nodal Officer (e.g. Project Director RCH or any other officer) who will be responsible for the identification of vulnerable groups including SCs/STs and urban slum population. The Tribal Health Plan will be prepared for the identified tribal blocks. Similarly, the District RCH Officer will be made responsible (Nodal Officer) for inclusion of the tribal component in the district proposals.

State governments will prioritize the cities for the preparation of urban slum health proposals by involving the local municipality. An officer will be designated who will be responsible for the preparation of the proposals, and the implementation and monitoring of the proposals. At the city level, an officer shall be designated as city program coordinator for implementing the Program.

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

At the national level, the Deputy Commissioner (ID), DoH&FW will be the nodal officer for the vulnerable group programs including urban slum health programs and tribal health programs and will coordinate with the National Health Resource Center and the state governments.

Appraisal

While appraising the state plans the appraisal team will also examine whether the state is adequately focusing on vulnerable groups or not.

National Health Systems Resource Center (NHSRC)

A National Health Systems Resource Center has been set up at New Delhi. The NHSRC 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 NHSRC to strengthen their efforts to improve the health status of the vulnerable. For details on the NHSRC, please see Chapter 3 of Document 1.

Coverage

The schedule for coverage is laid down in the PIPs for urban slums and tribal areas. For cities/towns having a population of less than one lakh, separate urban slum health programs 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 Phase II. Similarly in rural areas, the district plans will incorporate provisions to provide focused attention to SCs/STs and other vulnerable groups from the first year of RCH Phase II.

Monitoring and Evaluation (M&E)

The program will improve the monitoring and 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 Phase 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 disaggregation 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 NPCC will monitor the performance up to the state level. The states will monitor availability of quality services to the vulnerable population including those who are under-served 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 the district level. The districts will monitor performance at CHCs/PHCs and sub-center levels. Indicators will be based on measures of access by the vulnerable to those services. The concerned nodal officers at the state/district level will be responsible, inter alia, for formulation, effective implementation and monitoring of the activities taken up for vulnerable groups including the tribal and urban slum population.

Examples of Process Indicators

- Percentage of districts having identified vulnerable groups and having these groups included in their PIPs.
- Percentage of districts having conducted the consultation process with the stakeholders.

- Percentage of districts having conducted a facility survey and mapping up of available infrastructure and manpower etc.
- Percentage of districts, which have identified and nominated officers for the implementation and monitoring of the project.
- Percentage of districts having identified training institutions, the number of training courses conducted and training institutions identified for strengthening.
- Percentage of districts having developed a dependable referral system.
- Number of states having developed a 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 based on the age group.
- 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 programs for community workers, medical and para-medical staff and the extent of involvement of the community in the project formulation, implementation, monitoring and evaluation.
- Involvement of NGOs including outsourcing of services/institutions to the private sector for attending obstetric emergencies.
- Number of cases providing 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 the preparation of District Action Plans circulated with guidelines.)

1.6.4 Program Implementation Plan – Tribal health

Background

Tribal people (about 84 million) in India are considered to be the most socio-economically disadvantaged group. They constitute 8.2% of the country's total population. Their numbers, however, vary among the different states. The tribal development strategy of the GoI is based on the twin approach of the protection of the tribal people's interests through legislative and administrative support and the 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 center stage and the immediate objective is to address the unmet needs of health infrastructure, the training of health care personnel and contraception. One of the themes spelt out in the NPP relates to addressing the unserved/under-served areas with the focus on tribal areas.

Tribal communities of India cannot be clubbed together as one homogeneous group. They belong to different ethno-lingual groups, profess diverse faiths 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 six predominantly tribal states/UTs, - Arunachal Pradesh, Meghalaya, Mizoram, Nagaland, Dadra and Nagar Haveli and Lakshadweep where more than 50% of the population is tribal. The majority of the ST population lives in nine other states including Andhra Pradesh, Assam, Jharkhand, Gujarat, Chattisgarh, Maharashtra, Orissa, Rajasthan and West Bengal.

Rationale for tribal health component under RCH Phase II

Tribal communities have poor access to health services and there is also under utilization of health services owing to social, cultural and economic factors. Challenges such as demand side barrier structural constraints, Human Resource Development issues and the provider attitudes are particularly acute in tribal areas. (See Table 1.25)

Magnitude of health problems in tribal areas*

- The decadal growth rate of the 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 TT injections and only 48.6% are given iron and folic acid tablets.
- 8 1.1% of pregnant tribal women deliver at home, 44.4% of all deliveries are attended by TBA and 32.2% by other untrained persons.
- Only 14.1% have a postnatal check up within two months of birth.
- Unmet need for family planning is 15.4%
- 42% of the currently married women have a reproductive health problem
- High prevalence of falciparum malaria, tuberculosis, sickle cell disease, 0-6 PD deficiency, etc.
- Infant mortality is higher in the tribal areas compared to non-tribal areas.
- 79.8% of tribal children are anemic.
- Only 26% of children receive all vaccines.
- 55% of children belonging to scheduled tribes are 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 are not client friendly in terms of timing, cultural barriers, thus inhibiting utilization
- Lack of involvement by local traditional faith healers
- Weak monitoring and supervision systems.

Goal and objectives of the program

Goal: To improve the health status of the tribal community by the 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 an 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 Programs like Family Welfare/ RCH and the National Disease Control Programs as well as curative and referral services in coordination with the ongoing health and family welfare programs, along with associated supplies, management and information to both users and providers.

Strategy: To attain the above goals and objectives, the strategy will include the following.

- 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 the 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.

Human Resource Development

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

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 the Tribal Health Program under RCH Phase 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 programs are already under implementation, will be covered in the first phase of the project.

Service Delivery Model

Under the ongoing program of the MoH&FW, 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 it with (i) grassroots level support for service provision and the engagement and training of social workers/link volunteers/ASHA (preferably a literate woman from the community) who could maintain a link between the health facility and the community. NGOs and the 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.

In order to increase the 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 mobilizers, educators and providers of non clinical services; involvement of local elected bodies including tribal boards; and the promotion of the 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.

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 a major link in the inter-generational 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 in the table on the next page.

Tier	Service
Community Level	Community based worker/ASHA to work as social mobilizer, educator and 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.
Sub center	ANC and PNC services, IFA distribution, delivery by skilled attendant, referral for institutional delivery, contraceptive distribution and referral for terminal methods, immunization, management of childhood illness, de-worming, nutrition and health education for mothers, treatment of minor aliments including RTI/STI, services under national programs like DOTs, NMCP, counseling services.
PHC	All above + dispense ayurvedic, homeopathic, Unani and tribal system of medicines.
Block PHC/CHC	All above terminal method of FP EOC+ elective abortion 1st trimester, MVA, screening and clinical based services for sickle cell anemia, thalassemia, G-6 PD deficiency and lab services.

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 and FW services in tribal areas. Some of the interventions to be considered for financial support under the program are summarized below.

- Institutional strengthening to put in place a strong management structure for efficient implementation of the project by MoH&FW.
- 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 the 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

Community Level

The program envisages the provision of a community based female link worker/ASHA from the community to work as a social mobilizer, educator and provider of non-clinical services including as a depot holder for contraceptives. The link worker should be a woman from the village, who is able to spare three to four hours a day. She will be selected by the PRI and the ANM and trained by the PHC/NGO. She will work with an AWW under the guidance and supervision of the ANM/PRI. The payment of the honorarium should be linked to some minimum performance criterion to be decided by the MoH&FW/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 an honorarium
- Provision of the training component including refresher training, wherever necessary.

Sub-center level

- Renovation/up gradation of the existing facilities including the addition of staff quarters for ANM where necessary.
- Renting of accommodation for establishing new sub-centers.
- Equipment and furniture for services to be provided from the sub-center to be ascertained through a facility survey.
- Need based drugs and supplies including ISM/tribal/homeopathic medicines etc.

PHC

- Renovation/up gradation of the existing facilities including the addition of staff quarters wherever necessary.
- Recurring maintenance cost to be provided for the upkeep of the unit and equipment to the Block Medical Officer (BMO).
- Renting of accommodation for establishing new PHCs.
- Equipment and furniture for services to be provided from PHCs to be ascertained through a facility survey.
- Need based drugs and supplies including ISM/tribal medicines.
- Mobility supports either through the provision of a vehicle or a 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 programs) to medical/para-medical staff.

CHC/Block PHC

- Renovation/up gradation of the existing facilities including the addition of staff quarters wherever necessary.
- Recurring maintenance cost to be provided for the upkeep of the unit and equipment to the BMO.
- Support for need based additional laboratories/indoor facilities.
- Equipment and 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 supports either through the provision of a vehicle or a 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 programs) to medical/para-medical staff.

Public-private partnership (Tribal health)

Successful implementation of the project will require a vibrant partnership between the GoI (DoH&FW) and the state government. While the DoH&FW will provide technical assistance, the state government will provide leadership to the program 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 experiences across the globe in tribal health development and facilitate program design. The main specific interventions envisaged for support under the program are below.

- NGO 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-center/PHC/CHC where the public health system is deficient/inadequate.
- NGOs and corporate sectors should be encouraged to take up CBD projects covering a minimum of the 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 framework of partnership.
- Accreditation methods can be followed for private and NGO operated facilities. All facilities within the framework should follow a uniform reporting system and referral system.
- Outsourcing/franchising of discrete services (such as diagnostics) to NGOs/ the private sector.

Tribal health work plan

Under the program, the states are required to prioritize the tribal areas by doing facility mapping and baseline surveys 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 them to the 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 and state level is given below:

National level

- Preparation of guidelines and 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 the formulation of the project proposals. State governments may seek financial assistance for the preparation of tribal projects through technical agencies/consultants, if required.

State level

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

District level

- Needs assessment, including mapping of all existing health services run by the public sector and private sector including non-profit organizations.
- Baseline survey and 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: This component will be a sub set of the overall state/district level PIP. The funding mechanism for this component will be in conformity with that applicable to all the components of the ensuring /Reproductive and Child Health (RCH Phase II)/ National Rural Health Mission (NRHM).

- Sustainability: The support under the program will be limited to the project implementation period of the RCH Phase II Program. Therefore, it 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 detailed plan of action should address the issue of cost recovery, cost sharing and cost reduction. Pooling of resources, convergence, ownership and the commitments of the ICDS, the Tribal Welfare Board, the Departments of Civil Supplies, Rural Development, Panchayati Raj and Education of the state and central governments will ensure sustainability. The introduction of user fees depending on the socio-economic condition of tribal people may be considered in the later stages of the program.
- Monitoring and Evaluation: The program will be closely monitored at the national, state, district and village level and also will 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 and 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 CNAA (now CNAMA).
  - 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:
  - Alternative strategies to improve accessibility and the utilization of health/RCH services in tribal areas.
  - Improving skilled attendance in MCH care with special reference to deliveries.

1.6.5 Program Implementation Plan – Urban Health

Background

With increasing urbanization, 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 the development of a rural health system having a 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 three times in the last 50 years, the urban population has grown by 4.5 times during the same period (from 62 million to 285 million - 2001 census) and today constitutes about 27.78 % of the total population. Also the growth rate is far higher today for the urban population (3.16%) than for the total population (2.16%). Within urban areas the growth rate is the highest for urban slums. Recognizing the seriousness of the problem,

the Government of India has identified "Urban Health" as one of the thrust areas in the Tenth Five Year Plan, National Population Policy 2000, National Health Policy 2002 and the forthcoming 2nd Phase of the Reproductive Child Health Program.

Goal and Objectives of the Program

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

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

- To strengthen the existing urban health infrastructure by the renovation/ upgradation of existing facilities.
- The provision of establishing new facilities in urban slums areas, which are not covered.
- To support the development of a referral system for institutional deliveries, emergency obstetric care and terminal method of family planning.
- Involvement of the NGOs/private sector in the provision of primary health care services and also as part of the referral system.
- Integration of the existing health infrastructure with the proposed urban health program.

Program Description

As a part of the program, support for the implementation of urban health programs in the identified cities will be provided 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 north-eastern states. The latest 2001 census reveals that there are 423 towns/cities having a population of more than one lakh. Of these 423 cities, 28 cities have a population of more than ten lakh. 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, private nursing homes/hospitals, NGOs, etc. the proposed urban health program will focus on cities having a population between one to ten lakh (numbering 395 as per the 2001 census). Of the 395 cities, having a population between one to ten lakh, it is proposed to cover these cities in the phased manner as per the following:

Year	I	II	III	IV	V	Total
No. of cities to be covered	50	75	100	125	45	395

Depending upon the availability of funds the support to big cities having a population of more than ten lakh will be restricted to bringing an improvement in the quality of services. Other components will be need based and considered on a case-by-case basis.

Service Delivery Model

Under the ongoing program of the MoH&FW, different types of urban family welfare centers (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 the sterilization beds scheme. The post-partum centers (550 at the district level and 1012 at sub-district level) supported till 2002 by the GoI, are now being funded by the State Governments, with additional support from the planning commission. In addition, the other facilities run by the state governments/municipalities/NGOs/private sector are also available to provide primary health care services in urban areas. In view of the different nomenclatures and types of facilities, the program envisages the 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 Center (1 for 50,000 population) with the following proposed staff.

Medical Officer (MO)	- 1
ANMs	- 3-4 @ 12000-15000 population
Laboratory assistant	- 1
PHN/LHV	- 1
Assistant	- 1

To develop and maintain a link between the health facility and the community, the program envisages the engagement of social community workers/link volunteers, preferably females in the age group of 25-35, able to spare three to four hours a day, acceptable to the community, and 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:

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

II Tier

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

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

Type of Services

The I Tier Health Center will provide only 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 are as under.

- I Tier Health Center: Antenatal care, postnatal care, referral for institutional deliveries, immunization, services under national programs like DOTS, NMCP etc., family planning including IUD, NSV and referral for terminal methods, laboratory services, treatment of minor ailments including RTI/STI, depot holder services for contraceptives and ORS, promote/educate and help ANMs for outreach services through social community/link volunteers and support activities such as demand generation through targeted IEC training.
- II Tier Referral Center:
  - Institutional delivery
  - Emergency obstetric care
  - Terminal methods of family planning
  - II Tier curative services for RTI/STI

1.6.6 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 and 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 below.

- I Tier Health Center
  - Renovation/up gradation of existing facilities.
  - Renting of accommodation for establishing new urban health centers. This facility will include provision of space for services, office, minor OTs, laboratory and store-room for equipment etc., besides a patient waiting area.
  - No new construction will be supported under the program.
  - Equipment and furniture for services to be provided from the urban health center (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 a contractual basis only after redeployment of the existing staff.
  - Needs-based drugs and supplies (excluding supplies being made under other programs/schemes).
  - Mobility support (hired vehicle for referral services).
  - Support for services to be provided by NGOs will be considered on a similar pattern as per the specific agreement reached.
- II Tier Referral Center
  - Renovation/up gradation of existing referral facilities.
  - Support for need additional add on laboratory/indoor facilities

- Equipment and furniture for services to be provided from the referral centers (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 and supplies (excluding supplies being made under other programs/schemes).
- Support for services to be provided by NGOs will be considered on similar pattern as per specific agreement reached.

Public-private partnership (Urban health)

Successful implementation of the project will require a vibrant partnership between the DoH&FW, GoI, State Government and the Urban Local Bodies. While the DoH&FW 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 engaged for service delivery to fill in gaps. The donor agencies can provide technical assistance to the program by sharing experiences across the globe in urban health development and facilitate program design. The main specific interventions envisaged for support under the program are given below.

- NGOs and private nursing homes/hospitals may be involved in the program including service delivery through a framework of partnership.
- Accreditation methods can be followed for private and NGO operated facilities. All facilities within the framework should follow a uniform reporting system and referral system.
- Outsourcing/franchising of discrete services (such as diagnostics) to NGOs/private sector.

Urban health 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 the 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 and state level is given below.

- National level
  - Preparation of guidelines and 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 the public and private sectors 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 include:

- The setting up of a Technical Support Unit in state directorates.
- Capacity building and reorientation of key officials to state and urban local bodies.
- Constitution of a state level empowered committee and monitoring committees to approve the plan of action and monitor implementation respectively.
- Project Management Units will be set up in ULBs, including a management consultant depending on the city's population and mechanism of service delivery.
- Undertake IEC and procurement activities.
- Contracting out of services to the 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.

1.6.7 Funding pattern

- The funds flow will be from the GoI to the state government/state level society for further transfer to the implementing agency.
- Funding support would be provided for a maximum period of five years starting from the beginning of RCH Phase II.
- The ongoing urban health projects under implementation in the identified cities will be integrated and will become an integral part of the overall urban health program.

Personnel Cost

As regards the costing of a Health Center, the **indicative** costs of inputs based upon the IPP-VIII experience are as shown on the next page.

Equipment and Furniture

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

The cost for renovation and upgradation of the existing facility into a Health Center will be in the range of two to three lakh rupees. The rent for a new facility will cost around one to two lakh per annum. As regards the costing of services to be provided at the referral center and through public-private partnership, the costing would depend upon the specific interventions to be supported and the agreement reached with the private institutions.

Category of Personnel (Each health center)	No. of post Sanctioned	Recurrent / Capital	Monthly Expenditure (Rs.)	Annual Expenditure (Rs.)
1) Lady Medical Officer	1	Recurrent	12,600/- pm	1,51,200
2) LHV/PHN	1	Recurrent	6,500/- pm	78,000
3) ANMs	3	Recurrent	5,500/- pm	1,98,000
4) Link Workers	10	Recurrent	500/- pm	60,000
5) Security Guard @ Rs: 5000/- pm	-	Recurrent	4,000/- pm	48,000
6) Clerk	1	Recurrent	5,000/- pm	60,000
II. Annual Maintenance of Equipment, Furniture etc. Each health center	-	Recurrent	-	10,000
III. Electrical, Water, Building Charges etc.	-	Recurrent	-	50,000
IV. Building Maintenance Charges (Repair & Painting)	-	Recurrent	-	1,00,000
V. Drugs	-	Recurrent	-	30,000
VI. Training	-	Recurrent	-	1,00,000
VII. IEC materials	-	Recurrent	-	10,000
VIII. Hiring of Vehicles	-	Recurrent	-	1,75,000
Grand Total	**-**	**Recurrent**	**-**	**10,70,200**

Based on this 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 of that particular year.

Sustainability

The support under the program will be limited to the project implementation period of RCH Phase II. Therefore, it 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 detailed plan of action should address the issue of cost recovery, cost sharing and user fee.

Monitoring and evaluation

The program will be closely monitored at the national, state and city levels and also need to be evaluated from time to time. For this purpose, a committee will be constituted at the state level with the 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 and 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 CNAA.
- Concurrent evaluations by independent agencies.

2

Addressing Cross-Cutting Issues in State PIPs

The success of RCH Phase II will largely be determined by the extent to which it is successful in addressing inequity in access (of which gender inequity is the leading example).

As this chapter discusses cross-cutting issues, there is necessarily some overlap between the various sections. As is the case elsewhere in the RCH Phase II documentation, it can only present a summary of the far more detailed support documents to which readers are directed for more information.

2.1 Mainstreaming Gender and Equity in RCH Phase II

2.1.1 The extent of gender inequity

When there is a choice to be made it is often the girl who has a lower calorific intake, is breastfed less frequently, denied an education, engaged in caring for siblings, cooking, cleaning, and fetching water, fodder and fuel in rural areas. In urban areas, girls are involved in home-based work or as domestic help at very low wages, while boys are sent out to factories. The linkages between education, economic opportunities and livelihoods and access to health are not accidental. Even incremental improvements in status seem to translate into considerable benefits such as delaying the age of marriage and first conception and better birth spacing.

The lower the status of women, the lower the expectation of life at birth. A girl born in Uttar Pradesh can expect to live substantially fewer years than her peer in Kerala. Rapid growth accompanied by immense plasticity makes childhood a period of great vulnerability. Discrimination and neglect along with scarcity of resources overlaid on this vulnerability can initiate a life-long downward spiral of deprivation and exclusion. For girls in India, delayed, inadequate or no health care during illness contributes to the abysmally low sex ratio in india; girls' environmental disadvantage far outweighs their genetic advantage.

Roles prescribed by society for women and men in differential social contexts (tribal, rich, poor, etc.) determine the opportunities and resources available to them, their ability to make decisions related to protecting health and seeking care in case of illness.

> Gender roles and unequal gender relations interact with other social and economic variables, to produce different and often inequitable patterns of exposure to health risk and differential access to and utilization of health information, care and services. These differences clearly impact health outcomes.

While the overall poor quality of health services affects all, its effects on the poor are disproportionately high. More so, it affects poor women much more than women from more privileged sections of society. Even among the poor the situation of Dalit and tribal communities is worse. A recent qualitative study of women and children in diverse poverty situations revealed that basic indicators such as age of marriage, immunization and delivery assisted by skilled attendants are very low among the lowest quartile of the economic ladder. Gender cannot be viewed in isolation of social and economic status of people.

Qualitative studies from across India describe significant disparities in health care utilization and health status between women and men. Poor women consume less health care resources and suffer worse health than men and a large and increasing share of health expenditure by poor people is taking place outside of the public sector. Women in particular are known to make a number of trade offs in deciding which practitioners to consult. These include distance, [the opportunity costs of their] time, the perceived quality of the service (particularly the attitude of the provider), and the cost of treatment.

As women, more than men, tend to seek help for their children, integrated RCH Phase II services for women and children are needed and they should be provided by skilled and gender sensitive health care staff. State PIPs and Log frames must unequivocally address gender disparities in all operating procedures, service delivery practices and BCC activities without exception.

Table 2.1: Factors that Influence Women's Access to Healthcare

Economy, Society & Culture	Systemic Issues	Mindset and Attitudes
■ Poverty ■ Powerlessness ■ Status of women ■ Poor women preoccupied with survival ■ Self-perception ■ Post puberty practices and child marriage ■ Burden of work ■ Access to family income ■ Domestic violence ■ Preference for sons ■ The stigma of infertility	■ Physical access ■ Availability of providers ■ Dysfunctional facilities ■ Location and timing ■ Quality and cost of care ■ Clinical, communication and managerial skills of providers ■ Over-medicalized services ■ Women specific services ■ Multiple windows for services ■ Reliable referral services	■ Population control mindset ■ Primary focus on women of reproductive age ■ Discrimination against minorities and marginalized groups ■ Attitude of managers and service providers towards the poor, especially women ■ Attitude of providers towards adolescents & women out of wedlock ■ Absence of a rights perspective

Despite unanimity on the need for incorporating the issue of gender in the health sector, much remains to be done. There is huge scope for developing the skills, attitudes, and knowledge of staff designing State PIPs and Log frames, managers and health workers in gender specific methodological approaches and tools including gender specific needs analysis, monitoring and impact assessment.

2.1.2 Gender: Policy

GoI is committed at policy level to reducing the gender bias in public health and family welfare programs. The shift in policy and program focus from family planning and fertility control to reproductive health must be completed. Family welfare and women's health must be promoted as a responsibility shared by both men and women. Men and women should jointly decide on issues related to contraception, abortion, sexual health and sex education of children. For RCH Phase II to achieve its health outcomes, a deeper understanding of the care seeking behavior of women across different age, ethnic, religious and income groups will be necessary.

2.1.3 Mainstreaming gender in RCH Phase II state PIPs and log frames

Training officials and service providers and sensitizing them about the status of women - the injustice faced by them on a daily basis, gender-based violence, access to education, health care, nutrition, and control over fertility - is a necessary but insufficient response.

Experience over the last decade, especially in India, and notably in RCH Phase I, has demonstrated that while such training may impart information and may to some extent raise awareness of gender related issues, trainees often fail to see its immediate relevance to their work. Equally, training a group of people drawn from different districts and departments has limited value if trainees go back and work among people who have not shared the same experience. It can, at best, change the attitudes of a few individuals, but they will tend to lose their enthusiasm if they are isolated.

On the other hand, training programs that involve a group of people who work together and have different responsibilities in the same organization have greater impact. They not only reinforce and encourage each other, but this approach tends to create a positive institutional environment.

Gender sensitization training has marginal impact because:

- It is not a one-shot event, but a long drawn out process.
- It tends to overwhelm people with information and analysis, rather than enable them to identify what they can do in their daily work to make the system responsive to the needs of poor women.
- Planning, organization and management issues are not addressed simultaneously.

Addressing gender inequity is central to RCH Phase II and draws its legitimacy from GoI Policy and the overall goal and vision of the RCH Phase II program. Therefore, gender must be mainstreamed in all aspects of State PIPs and Log frames. The effectiveness of gender mainstreaming will depend on the extent to which States address it alongside issues of community participation, reducing disparities in social equity and the responsiveness of management.

Mainstreaming gender in RCH Phase II will be the most effective strategy to achieve gender equity. It is a process that seeks to integrate gender concerns into the formulation, monitoring and analysis of the RCH Phase II program. Gender mainstreaming is integral to the vision of RCH Phase II and its equity goals of serving the unreached segments of the population through need-based quality service delivery.

The social and economic barriers to women's access to quality services must be recognized and addressed through strategies in the State PIPs and Log frames.

Mainstreaming gender within a State's RCH Phase II PIPs and Log frames will require fuller understanding and consideration of the different needs, identity and behavior of women and men arising from their unequal social relations, and the awareness that, as a result, a State's PIP can benefit women and men differently. State PIPs and Log frames must take into account the well-being of women according to their own needs and expectations.

For State PIPs and Log frames, tackling gender inequity across the board is:

- **Not** optional
- **Not** an "add-on"
- **Not** a component

The aim of mainstreaming gender is to correct imbalances between the position of men and women in terms of access to resources and benefits as well as to understand the differences in terms of health status and health determinants.

For a State PIP to effectively mainstream gender, it must:

- Acknowledge gender as a key determinant of women's health, and actively involve women in planning, implementation and evaluation
- Be an integral part of a broader equity strategy to reach the most vulnerable, marginalized and poorest groups
- Be not only about "clients" but also about providers and institutional environment in which the RCH program is located.
- Not have a narrow focus on activities and service provision, but also address gender barriers to stimulate demand such as the attitudes and skills of providers, service planners and managers.
- Establish mechanisms to foster the participation of women in all aspects of planning, management, delivery and promotion of services.
- Address how to improve the responsiveness of the system so that it best meets the needs of the poor and of women.

2.1.4 Realistic strategies and activities for state PIPs and log frames

The strategy matrix identifies the social and economic barriers faced by women in accessing health care and corresponding service delivery system level actions or responses that can help address these barriers (Table 2.2)

Table 2.2: Strategy Matrix

Social & Economic Barriers	Service Delivery Response
Lack of control over one's body, one's reproduction	■ Provide access to contraceptives (spacing and terminal) ■ Provide access to confidential safe abortion (husband's consent not mandatory) ■ Provide easy access to health facilities and providers within reach ■ Provide counseling for both partners ■ **Promote these services and stimulate demand for them**
Lack of mobility	■ 24 hour services within easy reach ■ Fixed day services ■ Make drugs and consumables available ■ **Promote these services and stimulate demand for them**
Lack of access to resources	■ Reduce cost of care ■ Introduce health insurance schemes ■ Build linkages with SHGs ■ **Promote these services and stimulate demand for them**
Value/stigma attached to certain services	■ Educate community, PRIs and SHGs on gender and other RCH issues ■ Provide confidential and discreet STI/RTI and safe abortion services especially for adolescents ■ Ensure privacy and confidentiality ■ **Promote these services and stimulate demand for them**
Low education level	■ Provide educational messages through alternative channels ■ Provide help in negotiating with health services, especially at large, unfamiliar institutions (social worker)

Some practical examples of realistic activities to tackle gender inequity that may be included in State PIPs and Log frames are listed in Table 2.3

2.1.5 The extent of health inequity

Extensive health inequity persists in India. Evidence from various national sample surveys conclusively indicates unequal health outcomes and access to services according to social identity, socio-economic status, and geographical location.

Some of the facts:

- Almost half of children (47%) under three years of age are underweight, a measure of short and long term under-nutrition.
- Children from scheduled tribes are the most likely to be undernourished.
- Children born to illiterate mothers are more than twice as likely to be underweight or stunted as children born to mothers who have completed at least high school.

Table 2.3: Realistic Activities for State PIPs and Log Frames

Critical Issues	Options	Advantages	Disadvantages	Indicators
1. Increasing availability of women frontline workers	Make more ANMs available to provide 24 hr sub-center services. Establish nurse/ midwives at block level (public or contracted).	RCH services more available, especially safe delivery.	Resource intensive. Staff may not be willing to be posted. District/block would need to develop the skills to manage staff contracts.	% of deliveries attended by ANMs/ skilled birth attendants.
2. Moving skills closer to women and community	Extending the roles of ANMs and other staff to provide life-saving and other RCH services. Adapting and revising protocols to enable this extension of roles.	This is evidence-based (section 1.4). This would increase coverage and more efficiently use existing human resources.	Legal and professional body agreement is necessary. Doctors and senior staff may resent these moves.	% ANMs diagnosing and managing RTIs and providing EmOC % staff nurses trained in performing MVA.
3. Making services responsive and accountable	Orientation and training of managers and service providers on gender and equity issues.	Would encourage community involvement in service provision to become more need-based and accountable. PRIs may take responsibility for mobility and safety of ANMs, referral/ emergency transport available. Would encourage setting up mechanism for PRIs to be involved with facilities to monitor and strengthen them.	Community involvement would require ground level capacity building (NGOs?) Monitoring of community involvement would be qualitative.	% of women who expressed satisfaction with the services availed from the public system.
4. Reducing economic barriers faced by women	Recognize economic barriers to women accessing care and explore options for simple schemes (e.g. demand side financing based on vouchers for poor households, especially women).	Improved access to RCH services especially safe delivery.	Resource implication may be high for instituting a community health insurance scheme.	% of out-of-pocket expenditure women spend on health care.

- Early marriage of women keeps fertility high and increases the probability of high-risk births. 19% of total fertility is attributed to very young mothers (age 15-19). Children of very young mothers have an infant mortality rate that is almost one and a half times higher than that for mothers in their twenties.

> Even within States, there are large disparities between different socio-economic groups. Rural areas continue to lag far behind urban areas. Scheduled Tribe populations, followed by Scheduled Caste populations, are distinctly under-served. Similarly, religious groups differ greatly in their fertility levels, family planning acceptance rates, infant and child mortality, and utilization of maternal and child health services. In every State, special efforts are needed to reach rural women, scheduled tribe women, illiterate women, and poor women, who continue to be left out of the process of national development. The likelihood of success of health and family welfare programs will be greatly enhanced if they can be tailored to meet the specific needs of the groups they are meant to serve.
>
> *-NFHS II, page 24, Conclusions*

- 52% of women aged 15-49 and 74% of children aged 6-35 months are anemic. The lower the woman's education and the poorer the household, the higher the risk of anemia among both women and children. Risk of anemia also increases in rural areas and for scheduled tribes and scheduled castes.
- Boys and girls are equally susceptible to diarrhea and ARI, but boys are more likely than girls to be taken for treatment to a health provider.
- Older women, rural women, and socially and economically disadvantaged women are less likely than others to deliver in institutions or to have a health professional present at the time of delivery.
- In the first month of life, the risk of dying is higher for males than for females, but after the first month of life, when factors other than biological ones begin to dominate, female children face an increasingly greater risk of dying than male children. The risk of dying between ages one and five years is 47% higher for females than for males.

At the aggregate level, children from scheduled tribes, scheduled castes and poor households have the highest risk of neo-natal, infant and child mortality. Maternal mortality estimated through using the sisterhood method suggests that women from scheduled tribe and scheduled caste groups had higher maternal mortality ratios than other women.

2.1.6 The causes of health inequity and vulnerability

Tribe, caste, poverty, region and religion, all exercise a powerful influence over mortality and morbidity rates. Poor children are more exposed to risk of disease due to inadequate water and sanitation, indoor air pollution, crowding and poor housing conditions, and high exposure to disease vectors. They are also more likely to have lower resistance to infectious diseases because they are undernourished (an underlying cause of about 50% of deaths in children younger than 5 years), as well as to have diets deficient in one or more essential micronutrients, to have a low birth-weight as a result of poor maternal nutrition, infections during pregnancy, short birth intervals and to have recurrent disease episodes.

Poverty thus increases exposure and reduces resistance to disease which is then further compounded by inequities in coverage of preventive interventions, making poor children even more likely to become sick and require curative care compared with their better-off peers. Infants and young children run increased risks of ARI due to their immature respiratory systems. It is estimated that approximately 90% of the diarrheal disease burden is related to environmental factors of poor sanitation and lack of access to clean water and safe food.

2.1.7 Demand-side barriers to accessing services

The availability of a health facility does not guarantee its use. Several barriers (financial, social, cultural and informational) have been identified that discourage the poor from using public health facilities, causing them to turn to the private sector and incur avoidable costs, engage in self treatment, or simply bear with poor health if they cannot pay the "nominal" fee at public facilities.

One of the most critical factors influencing public health service utilization is "user charges" accompanied by limited provision for medicines and emergency services. For the poor, user fees at government hospitals have no "value addition" if medicines are not provided or if critical services like STD treatment and emergency services are not available. The hidden cost of using public health services such as travel costs, wage loss, cost of consumables and bribes/tips for health staff make public health services even more unattractive to the poor and marginalized. Further, such hidden costs make public services nearly as expensive as private services, especially for the more common outpatient ailments. In many urban areas, the cost of institutional delivery is a reason why the poor prefer home deliveries, especially for higher order parities.

The opportunity costs of inconvenient timings and long waiting times at public facilities pose significant additional barriers to low-income users who lack flexibility in their working hours. Seeking care in private clinics is quick, easy, and more convenient.

2.1.8 Service related barriers to access

Potential users are discouraged by the poor work ethos at government centers, corruption, slow work culture, lack of basic equipment, and lack of suitable staff such as female doctors and male health workers.

The absence of female doctors in many PHCs, is a major deterrent to women and adolescent girls resulting in delayed care seeking and increased informal health care seeking. The system of referral to higher health facilities is yet another deterrent in availing public services as users prefer a "one window service" that will reduce their time and travel costs. Referral often results in the loss of patients to the other care sectors, mostly to the informal and unregulated sector.

Rudeness and insensitivity of staff to the needs and constraints of users further discourages them from availing services. Lack of respect for patients, outright discriminatory behavior, lack of regard for their privacy and dignity, use of abusive language, harsh and often violent handling of patients, particularly women admitted for delivery, and an unsympathetic approach pose significant difficulties to low income users who cannot afford treatment outside. The common perception that government services are substandard, ineffective and unfriendly is a direct result of users' negative experiences of providers.

2.1.9 Health expenditure: Who benefits from public health financing?

Across India, there has been a proliferation of private hospitals, clinics and diagnostic centers. Nationwide data shows that that the poor form the greatest proportion of the private sector providers' workload. A study of one district in India estimates that 84.6% of the poorest 20% visited private providers.

Out-of-pocket expenditure on health is by far the main financer of health care in India across all socio-economic groups, and trends in health-seeking behavior since the mid-80s suggest an increasing squeezing out of the poor from accessing health care and worsening class inequality.

Benefits incidence analyses of public health financing have found that the wealthier benefit significantly more than the poor. The poor benefit more from primary and preventive interventions and the better-off from secondary and tertiary hospital care.

2.1.10 Strategies for mainstreaming equity and access in RCH Phase II

2.1.10.1 Setting equity objectives for RCH Phase II

RCH Phase I laid the framework for a reproductive health and client-centered approach, and embraced a paradigm shift in policy. RCH Phase II builds on the achievements and lessons of RCH Phase I, and will extend and deepen the paradigm shift and benefits from the more recent policy commitments made to equity. Equity of health outcomes is now at the heart of national policy, and at the heart of the RCH vision. To achieve greater health equity, RCH Phase II refers to the need to "address access, equity, vulnerability and gender issues" at the level of program policy. To translate the policy level commitment into practice, it is essential that equity objectives with measurable indicators and benchmarks are established for RCH Phase II, priorities identified and State PIPs and Log frames developed.

The combined picture of health disparity between population groups that emerges has gender, geographical, social, economic, age, and livelihood dimensions as detailed below:

- Disparities between women and men.
- Disparities between scheduled tribes and non-tribal populations.
- Disparities between scheduled castes and other castes.
- Disparities according to religion; for example, Muslims having a higher unmet need for contraception.
- Disparities between socio-economic groups.
- State disparities particularly between the EAG and non-EAG States.
- Disparities between districts even in better performing States.
- Sub-district pockets of extreme deprivation.
- Disparity between urban and rural populations, with urban populations at the aggregate level achieving better health outcomes, but the urban poor having significantly poorer health outcomes.
- Disadvantage of unmarried adolescents in having their RCH needs met.
- Disadvantage of the elderly in having their reproductive health needs met.
- Certain livelihoods expose people to health risks and inhibit their capacity to access services. Among these are migra'nt workers and miners.

From the above we see that the target populations that need to be addressed in pursuit of health equity outcomes are extremely diverse, they are both spread across India (women, adolescents, elderly, scheduled castes), and concentrated in geographical areas (EAG States, scheduled tribes, urban poor, migrant workers).

The RCH Phase II equity objective is:

"To reduce the health inequities both between geographical areas and between social groups, and to respond to the needs of vulnerable populations."

Indicators and target levels of achievement need to be set in State PIPs and Log frames to track progress on equity and link equity performance to positive program rewards.

Equity data from NFHS-II and the RCH Random Household Survey (RHS) will be used to set a national equity baseline using a mix of health outcome and health service use indicators. This short-term use of existing databases will need to be improved upon to produce a more robust baseline and set of indicators in the future.

The DoH&FW needs to take on the role of championing equity, taking responsibility for reducing national RCH inequities and being accountable to policy-makers for performance, creating the know-how and capacity to shift policy into practice throughout the system, and ensuring that systems are in place to track and evaluate equity-boosting interventions to learn lessons on what reduces inequity and how. This new role for DoH&FW and responsibilities need to be factored into the planned organizational review of the department.

2.1.10.2 Empowered Action Group mechanism

The EAG mechanism was formed in order to address the disparities in health outcomes between the more advanced States and States such as Bihar, UP, MP, Rajasthan, Orissa, Jharkhand, Uttaranchal and Chattisgarh which together account for the country's most adverse RH outcomes and fertility. The EAG is intended to function as a fast-track mechanism for clearing proposals and enabling inter-sectoral convergence.

The EAG is currently located within the Ministry of Health and Family Welfare. As such it has all the advantages and disadvantages of any unit within government. It has authority at the highest level to approve funds with minimum delay. The challenges in the EAG States, however, require a well-resourced support mechanism that can create and maintain the momentum of RCH Phase II. The EAG presents a rare opportunity for convergence. However there is no evidence that this has been systematically prioritized with a view to achieving the three health outcomes of reduction in population growth, IMR and MMR for the EAG States.

2.1.10.3 Mainstreaming equity and access state RCH Phase II PIPs and log frames

RCH Phase II's emphasis on State ownership and the differential approach has created the opportunity for equity mainstreaming within the States. In order for equity to be positioned as central to RCH Phase II, it must be consistently integrated into State planning, management, monitoring and accountability processes. The States must also have ready access to expertise to support them and to build State capacity and systems to direct resources to equity issues.

From the capacity assessment of 4 EAG States it is clear that considerable capacity building will be required to mainstream equity and access into integrated planning. The planned institutional review of

National Indicators of Health Equity

Neonatal mortality

- Reduction in the disparity between the NNMR of the lowest socio-economic group and others.
- Reduction in the disparity between the NNMR of scheduled tribes and other social groups.
- Reduction in the disparity between the NNMR of scheduled castes and other social groups.

Infant mortality

- Reduction in the disparity between the IMR of the lowest socio-economic group and others.
- Reduction in the disparity between the IMR of scheduled tribes and other social groups.
- Reduction in the disparity between the IMR of scheduled castes and other social groups.

Child mortality

- Reduction in the disparity between the under-5 mortality rate of the lowest socio-economic group and others.
- Reduction in the disparity between the under-5 mortality rate of scheduled tribes and other social groups.
- Reduction in the disparity between the under-5 mortality rate of scheduled castes and other social groups.
- Reduction in the disparity between under-5 mortality rate of girls and boys.

Maternal health

- Reduction in the disparity between the proportion of pregnant women that receive full antenatal care in the lowest socio-economic group and others.
- Reduction in the disparity between the proportions of pregnant women that receive full antenatal care from scheduled tribes and other social groups.
- Reduction in the disparity between the proportion of pregnant women that receive full antenatal care in the 35+ age group to younger ages.
- Reduction in the disparity between the proportions of pregnant women receiving TT vaccinations from scheduled tribes and others.
- Reduction in the disparity between the proportion of deliveries assisted by a trained attendant in the lowest socio-economic group and others.
- Reduction in the disparity between the proportions of deliveries assisted by a trained attendant for scheduled tribes and other social groups.
- Reduction in the disparity between the proportion of deliveries assisted by a trained attendant for scheduled castes and other social groups.

Women's health

- Reduction in levels of anemia among scheduled tribes.
- Reduction in levels of anemia among scheduled castes.
- Reduction in levels of anemia among the lowest socio-economic group.
- Reduction in levels of anemia among 15-19 year olds.

Geographical inequity

- Reduction in the difference between the above key health indicators in the EAG States compared to non-EAG States.
- Accelerated improvement in health outcomes of the poorest performing 100 districts.

Urban health

- Reduction in the disparities between the health outcomes of the urban poor and the urban non-poor.

each State will build on the analysis and recommendations of the social and gender equity studies, and identify the structures, staffing, skills and tools that need to be developed to strengthen the State's capacity to operationalize the pursuit of greater equity.

Each State PIP must include equity objectives and measurable indicators against which performance can be monitored, and baseline values of the criteria against which the State PIPs and Log frames are appraised.

2.1.10.4 Equity monitoring

Concurrent equity monitoring at State and district levels through the RCH Random Household Survey will provide evidence of equity trends.

In the medium term (2006-7), planned household surveys will be designed to produce more robust and disaggregated equity indicators that can track changes in behaviors and social and cultural determinants that impact on health outcomes. This will require expanding the sample size of the current RCH household survey, and possibly the broadening of social and behavioral questioning to detect changes in the underlying attitudes and behaviors of RCH outcomes.

As recommended by the Planning Commission and the HDRs, two distinct indices will be developed for each State; a disparity index based on RCH Phase II outcomes, and a discrimination index based on RCH outputs and processes.

States will be encouraged to set out, in their PIPs and Log frames, plans to develop a quarterly updatable website on inputs and resources provided for RCH services, including financial, human, and material resources (medicines and equipment). Public disclosure of information practices will inform and enable the public to monitor service standards and hold providers, managers and policy-makers accountable for deficiencies.

2.1.10.5 Mainstreaming equity in district planning, management and monitoring

State PIPs and Log frames should include plans to:

- Undertake an equity analysis and develop district equity baselines and equity objectives which can be used to track district-level trends.
- Forge alliances and convergence with stakeholders to maximize support for equity objectives and interventions.
- Develop micro-level plans that identify vulnerable groups and form the basis for targeted interventions and monitoring of their outputs.
- Enable decentralized planning to make a difference by strengthening district and block managers' knowledge and authority to use resources responsively to better reach and serve disadvantaged groups.

In many parts of India, district RCH planning has been a mechanical exercise based on demographic statistics and assumed levels of fertility and family planning, without attention to the social dimensions of health use or the multiple determinants of health outcomes. The RCH RHS provides district-wise data that starts to identify the social factors that impact health use and health outcomes. However, the current district sample size is too small to provide a robust measure of health outputs by population groups. It will be redesigned and expanded to enable districts to develop equity baselines and set equity objectives.

2.2 Community Participation

Community participation and ownership, an established tenet of the success and effectiveness of health services, is founded on the belief that the best way to improve health outcomes and the performance of health systems is to offer communities ways by which to take greater control of their health. 'Participation,' nonetheless, cannot be a substitute for poor services. Therefore, a minimum level of health service provision and standards must be ensured to get community 'buy-in' for participation.

Constraints to greater and more effective participation include:

- Poor health worker appreciation of the value of participation
- Poor health worker skills in facilitating community involvement
- Lack of accountability for the services being provided
- Weak political commitment towards community involvement
- Lack of structures for communities and health services to plan jointly.

Power relations impact on the partnership implied in participatory systems. Health workers may use their knowledge or technical status to over-ride community inputs. Political authority may marginalize civic input. Genuine participation needs to find structures, processes and tools that enable different forms of authority to interact productively. Policy guidelines on participation should be clear and available to the public to facilitate their role.

Lack of real resource control and the inability of the district to respond to their resource demands poses a real obstacle to effective planning at community level. This calls for a clearer definition of partnerships from State to districts and further down between communities and health providers. It also calls for sharing of relevant information and training of democratically elected bodies.

Resources need to flow to give substance to authority. Where State control over resources does not match local planning, participation is undermined and discouraged. The provision for some local authority over budget allocation towards defined needs is necessary. This is very pertinent to the RCH Phase II model of strengthening decentralized health planning and building linkages with PRIs.

Significant investment in building capacities, tools and information for 'bottom-up' planning, needs assessment, community surveillance and in making information accessible in local languages would be necessary. Mechanisms for facilitating community participation would need to consider how community priorities would be integrated into health planning and with budget and resource allocation processes. Tools for priority setting should necessarily link public perceptions to evidence-based processes. A poverty focused health enhancement strategy calls for multisectoral approaches that is likely to conflict with sectoral bureaucracies. This is best overcome through bottom-up, integrated planning with resources that can respond to such planning.

GoI recognizes the need to involve communities, their elected representatives and civil societies in the planning and monitoring of RCH services and in making them partners in delivering and monitoring the quality of care being offered. It also recognizes that individuals and families need to move towards adopting healthy lifestyles to keep themselves and their children healthy.

When designing their PIPs and Log frames, States must:

- Recognize that decentralization may not benefit poor and marginalized groups and that an overall improvement in health service provision does not necessarily benefit these groups.

- Establish mechanisms to reach these populations and give them a "voice" during planning, designing and monitoring RCH Phase II.
- Ensure that Community Convergent Action is integrated into their PIPs and Log frames and monitoring activities and cooperation with all elected bodies, other departments, NGOs and the private sector.

2.2.1 Accountability and voice

Citizen voice initiatives in the health sector are growing but are not well connected. Vertical accountability to citizens generally takes the form of presence in management committees, but lacks the strength to enforce changes or address grievances. The Right To Information Bill has now created space for civil society to make stronger claims, and there are examples of how access to information is enabling citizens to challenge use of government resources.

2.3 Stimulating Demand

As has been noted above, the provision of services does not guarantee demand for them. Many of the constraints to demand are discussed in other sections of this document, most especially in the section immediately above (Mainstreaming Gender and Equity) but also in tribal health, urban health, adolescent health, maternal and newborn health. A brief summary is presented below.

RCH Phase I was predominantly a supply-driven project, and if RCH Phase II is to achieve its objectives it must be based on a deeper understanding of the constraints on the demand side and how they might be best tackled in the State PIPs and Log frames.

2.3.1 Barriers to demand

Household and community

Gender and equity barriers are of paramount importance in determining a community's response to RH services and are discussed in more detail above.

Knowledge and behavior are vital in shaping health outcomes through their impact on prevention, health-seeking behavior and compliance during treatment. A GoI Social Assessment study shows that the majority of women, and especially poor women, lack knowledge and information about services. Mothers' age and education level influences demand and utilization.

Lack of community participation in creating awareness, planning and monitoring of health facilities can lead to low demand in a community.

Poor geographical accessibility and the opportunity costs of traveling significantly reduce demand.

Inadequate mobilization of health care resources to bring together the private sector, NGOs, tribal practitioners etc. is a lost opportunity to stimulating demand.

Cost, notably hidden "unofficial" costs at public facilities that are supposed to be free, is a strong barrier especially to the poor, women and adolescents without access to household money.

Program level

Weak decentralized management (as demonstrated in RCH Phase I) leads to a lack of flexibility in programming and a "one size fits all" approach with little differentiated strategy for groups with special needs and weak demand.

Poor governance and lack of accountability and the ensuing lack of availability of personnel and supplies is a strong disincentive to demand.

Provider attitudes, as described above, are very significant barriers especially to women, adolescents, tribal people and the poorest.

Perceptions of poor quality due to lack of staff in post, non-availability of female staff, lack of privacy and confidentially, poor infrastructure, lack of drugs etc.

Policy constraints

Lack of appropriate policies and legal framework such as the restriction on the drugs ANMs can use even in emergencies.

Cross-sectoral issues: Other sectors influence demand, for example, education, access to water and sanitation.

2.3.2 Strategies to stimulate demand in the State PIPs and Log frames

Household and community level

Addressing the gender and equity barriers to access: As described above, addressing these issues will be *paramount* if RCH Phase II is to achieve its goals. Strategies and indicators are described above, and further aspects are discussed in Chapter 3.1.

Stimulating demand and access through participatory approaches to RCH Phase II service planning and delivery through interventions such as:

- Involving community groups in planning exercises has been shown to lead to less duplication, bonds between communities, NGOs and governments and improved community understanding of health and gender issues.
- Providing outreach services with community participation has been successful in reducing infant and maternal mortality and increasing CPR and immunization coverage.
- Peer motivators are effective in providing RCH counseling and services.
- Women's groups can raise awareness of RCH needs and rights and to mobilize and strengthen the capacity of women to utilize services.
- Participatory monitoring tools such as the home-based maternal record have proved effective in involving families and an increased detection of women with complications during pregnancy.
- Involving men (who are often the decision-makers on issues like contraception) has led to changes in their sexual attitudes and behavior.

Reducing the cost of care in the public sector and protecting the poor from the financial consequences of illness by:

- Strengthening public health facilities to provide reliable and quality RH services that are free to the poor and act as a "safety net".
- Establishing mechanisms of risk-pooling. The "free" services offered at public facilities may carry substantial opportunity and hidden costs.
- Cost exemption schemes for BPL families must be strictly applied and their existence promoted.

Public Private Partnerships (PPPs) to increase service coverage. NFHS II indicates the overwhelming dependence in rural areas on private providers for self-referred gynecological ailments. Examples of PPPs include:

- Using public funds to "purchase" RCH services for the poor from NGOs and private health providers, and actively promote these services. This has the potential to increase demand for, and access to, RCH services.
- Contracting private sector support services (training, communications, emergency transport, cleaning services, kitchen, laundry and security services) has been successful in many States.
- Involving private practitioners in government training programs can be successful. In Karnataka, 37% of private practitioners trained in STIs had improved treatment outcomes and patient satisfaction after the training.
- Utilizing the private sector for social marketing. Social marketing has been shown to be successful in the marketing of condoms and pills.

In preparing State PIPs and Log frames, the first step would be to map the availability of private providers and facilities, and enter into a dialogue to assess in which areas the private sector might be willing to collaborate.

Program level

Focused interventions in the area of institutional strengthening can contribute significantly to improving RH outcomes:

- Targeting services appropriately can substantially increase demand. Such interventions have been extensively adopted by NACO in India.

Improving governance and accountability :

- Introducing strong monitoring mechanisms has been instrumental in strengthening service delivery and having a positive impact on outcomes. This can include: *program monitoring*, as in the Rural Women's Development and Empowerment Project, where it led to areas of concern being brought to the attention of managers and addressed.
- Enhancing provider accountability by developing a "results framework" for which providers are accountable.
- Quality assurance (QA) programs were introduced in the State Health Systems Development Projects.
- Community monitoring such as in the Tamil Nadu Integrated Nutrition Project using community growth charts was successful.

Building capacity by:

- Prioritizing a few critical measures and vigorously applying them. Operations research from Maharashtra showed an increase in demand for RH services by women following four critical policy changes: service delivery was changed from household visits to a clinic base, stringent monitoring was done, in-service training for health workers was instituted and the range of services increased.
- Training health workers in short courses such as anesthesia, EmOC and extending the roles of ANMs and grassroots workers. Training can also bring about attitude change. For example, in Mumbai after intensive training in attitude change, midwives had better communication skills, were less judgmental of unmarried pregnant women and had increased confidence in their skills.

2.4 Convergence

2.4.1 The concept of convergence

Multiple sectors with different strategies, programs and projects increasingly develop a closer focus on the needs of their beneficiaries. There are enormous potential benefits from such a synergy.

Policy makers have reiterated time and again the need to undertake more inter-sectoral and preventive tasks at community level including immunization, ANC, anti-tobacco education, water, sanitation, timely spraying for malaria , nutrition counseling and food security initiatives to impact on maternal and child health outcomes.

RCH Phase II needs to move from recognizing these linkages to mandating and operationalizing inter-sectoral convergence by freeing up budget lines and enabling joint programming towards common objectives at local level.

2.4.2 The potential of convergence

If RCH Phase II can stimulate sector convergence, outcomes will be achieved more quickly and more efficiently. The following matrix outlines potential sector linkages and their impact on RCH Phase II outcomes.

The report of the Steering Committee on Family Welfare for the Tenth Five Year Plan has observed the following:

Inter-sectoral coordination, especially between the Departments of Health, Department of ISM&H, Women and Child Development, Human Resource Development, Rural Development, Urban Development, Labor, Railways, Industry and Agriculture, is critical for increasing the coverage of the family welfare programming to improve implementation. Some of the areas where inter-sectoral coordination is envisaged in the Tenth Plan include:

- Involvement of the extension workers of these departments in propagating BCC messages on reproductive and child health care to the population whom they work with.
- Efforts to improve the status of the girl child and women, improving female literacy and employment, raising the age at marriage, generating more income in rural areas, improving the nutritional status of women and children.

Table 2.4: The Potential Impact of Linkages

Sector	Child Health	Maternal Health	Disease Control	Newborn care
Rural development	High	Very high	High	High
Urban development	High	High	High	High
Roads	High	Very high	Moderate	High
Women & Child Development	Very high	High	Moderate	Very high
Forest Department	In tribal areas high	In tribal areas high	Tribal areas high	In tribal areas high
Education	Very high	Very high	Very high	Very high
Public-Private partnerships	Very high	Very high	Very high	Very high

- Coordination among village-level functionaries such as Anganwadi workers, TBAs, Mahila Swasthya Sangh, Krishi Vigyan Kendra volunteers and school teachers to achieve optimal utilization of available resources.

2.4.3 Convergence with other departments

2.4.3.1 National AIDS Control Program (NACP)

The HIV/AIDS epidemic in India is complex. In some States certain vulnerable populations like intravenous drug users, sex workers, truckers, and men who have sex with men have high prevalence rate of HIV infection. In States like Andhra Pradesh, Karnataka, Tamil Nadu, Maharashtra, Manipur and Nagaland the prevalence among antenatal attendees, which is a proxy for prevalence among the general population, is around 1.25% (based on sentinel surveillance data 2003). The index of vulnerability is based on extent of migration, size of population, and poor health infrastructure. Among the highly vulnerable States are Bihar, Rajasthan, MP, UP, Uttaranchal, Chhatisgarh, Jharkhand, Orissa, and Assam. This includes all the EAG States of the DoH&FW.

There is a pressing need to scale up prevention strategies based on factors of risk, vulnerability and impact, expand delivery of interventions and ensure that populations at risk and vulnerable groups are reached. India is at a stage in the epidemic where all sexually active individuals must be offered information and services on preventive interventions. Sexually active youth, particularly girls, are at high risk given the paucity of needs-specific information and services. HIV/AIDS infection prevalence is increasingly acquiring gender connotations.

Sentinel surveillance data also show that women account for more than half of all infections in rural areas (nearly 60%) and about two-fifths of all infections in urban areas. Sentinel surveillance sites are located mainly in either antenatal clinics or in STD clinics. Given the fact that most STD clinic attendees are men, it can be assumed that most women who are positive are also pregnant, a rather ominous sign for risk of transmission to newborns, and a substantial justification to expand the number of sites offering Prevention of Parent to Child Transmission (PPTCT).

Convergence between the National AIDS Control Program (NACP), with over a decade of experience and technical competence in HIV/AIDS prevention and care interventions, and the Health and Family Welfare program (H&FW), with its infrastructure, human resources and capacity to reach every village and community, is critical to ensure scaling up and effective service delivery.

Behavior changes, prevention/management of RTI/STI and condom promotion are the cornerstones of HIV/AIDS prevention. All three areas have a significant degree of overlap with interventions in the RCH program, since target groups and services fall in the same category. Other areas of prevention linked to HIV/AIDS interventions and which have implications for services in the H&FW program are Voluntary Counseling and Testing, (VCTC), PPTCT, and ensuring safety of blood and blood products. Comprehensive HIV/AIDS Programs include components of both prevention and care. VCTC and PPTCT are two areas of overlap between prevention and care strategies. Areas of cross-cutting importance that need to be addressed in prevention and care strategies include gender, private sector involvement, and reduction of stigma and discrimination among health care providers and communities.

Framework for Convergence Between DoH&FW and NACP

Area of Convergence	Role and Functions of DoH&FW	Role and Functions of NACP	Convergence mechanisms/aspects
RTI/STI	■ Primary Responsibility - integrate RTI/STI management at all levels in public sector system ■ Increase private sector involvement in high quality RTI/STI treatment ■ IMA and FOGSI. ■ Broadly RCH Phase II strategies should be followed ■ At PHC level, first line drugs to be offered, district, CHC and FRU to offer comprehensive etiological and lab based treatment. At district level, linkages with STD referral labs to be strengthened.	■ Support to HRG-NGOs to continue. Service delivery whether directly through NGOs or referral to public or private sector. ■ Ensure that all STI service data and special studies are provided to Joint Consultative Working Group (JCWG) to enable reporting at the convergence committee level.	■ At National level, NACP and DoH&FW to set up a JCWG group to monitor access of RTI/STI services for general population and for HRG. Report to HIV/AIDS Convergence Committee. ■ Training of providers (public, private and NGO) and lab techs. within purview of DoH&FW. ■ DDG-MH/NACO
VCTC	■ Infrastructure space to be provided in facilities where VCTC are located. ■ Support to ensure referral from other departments ■ Overall supervision by head of facility, in collaboration with Ob/Gyn, STD, Paed, and other depts. ■ Frontline providers to motivate community at risk for VCTC	Primary responsibility : ■ increase VCTC sites. ■ Expansion in phased manner. ■ NACP support for staff and supplies. ■ Include Youth Friendly Information Centers at CHC and PHC. ■ VCTC to serve other counseling needs. ■ Cadre of counselors to staff the sites.	■ JCWG to review functioning of VCTC through periodic State reports. Report to HIV/AIDS Convergence Committee ■ Training of providers of DoH&FW at all levels to include elements of risk protection, motivation for testing through DoH&FW ■ NGO training facilitated by NACP, but modules jointly developed. ■ NACO/DDG-MH
PPTCT	■ Overall supervision by head of facility. ■ Located in Ob/Gyn department, managed by HOD. ■ Ensure non-discriminatory practices. ■ Ensure universal precautions. ■ At the community level, ANM/ASHA follow up of VCTC clients testing positive for ANC, and motivate for PPTCT.	Primary Responsibility to ensure functioning PPTCT ■ Expand PPTCT sites in a phased manner. ■ NACP to support once counselor and lab. Tech. and supplies for PPTCT.	■ JCWG to obtain data on functioning of PPTCT and review performance ■ Training for all providers to include attitudinal as well technical skills, and universal precautions. ■ DoH&W ■ Private sector through IMA and FOGSI ■ DoH&FW/NACO/DDG-MH

Contd...

Area of Convergence	Role and Functions of DoH&FW	Role and Functions of NACP	Convergence mechanisms/aspects
BCC	■ All messages for HFW to include HIV/AIDS prevention and care and support as appropriate. ■ Ensure that NGO programs also use message content as defined.	■ Messages for HIV/AIDS highlight appropriate service provision through public and private health system. ■ Ensure that NGOs highlight service access in addition to prevention messages.	■ BCC strategy/division for NACP and DoH&FW under single management.
Condom Promotion	■ Enhance condom use for dual protection. ■ Female condoms to be promoted as a contraceptive/barrier method.	■ Condom promotion key to prevention. ■ Female condoms to be promoted as a contraceptive/barrier method.	Condom procurement and distribution for FW and NACO under single entity.
Training	Primary Responsibility for training of all service interventions (except VCTC/ PPTCT) to be within DoH&FW. ■ Support training content and technical support for VCTC and PPTCT training.	■ Support training in terms of content and technical support. ■ Primary responsibility for training VCTC counselors in a range of issues including HIV/AIDS, which include safe motherhood, family planning and childcare. PPTCT staff training also to be conducted by NACO/SACS.	■ NACP to coordinate with groups working on RCH Phase II modules to ensure HIV/ AIDS content for all workers. ■ Joint Working Group to be instituted to review and ensure that HIV/AIDS messages and content for training are tailored to each level of provider. ■ Ensure that training modules are shared with NGO partners of DoH&FW and NACP. ■ Develop protocols and guidelines for key services. ■ Ensure dissemination of protocols and guidelines to NGOs and private sector.
Reporting	DoH&FW MIS to capture service data- RTI/STI, VCTC, and PPTCT ■ MIS to include HIV/AIDS indicators ■ Support sentinel surveillance data collection	■ Ensure that VCTC, PPTCT, and sentinel surveillance data is reflected in district MIS.	■ NACP to coordinate with RCH Phase II MIS convener (CD, Statistics to ensure that HIV/ AIDS indicators are included in MIS for RCH Phase II. ■ Joint Working Group to review RCH Phase II MIS and ensure that reporting of RTI/STI, VCTC, and PPTC is also included. ■ Surveys (NFHS III and DLHS) to include information on HIV/ AIDS as well.

Contd...

Area of Convergence	Role and Functions of DoH&FW	Role and Functions of NACP	Convergence mechanisms/aspects
Blood Safety	Maintain quality of blood taken from blood banks to blood storage centers at secondary levels of facilities.	■ Primary responsibility to assure safety of blood at banks at district level and above	

2.4.3.2 The Department of Women and Child Development (DWCD)

As part of the RCH Phase II program, the child health strategy concentrates on the following: essential newborn care, breastfeeding, immunization, and care of the sick newborn and child through outpatient/ home based care and inpatient care. This approach is called the Integrated Management of the Neonatal and Childhood Illness (IMNCI). The table below provides details on the maternal and child health services provided at the village level.

Table 2.2: Strategy Matrix

DWCD Interventions	DoH&FW Interventions
Child health ■ Monthly weighing of children under six ■ Maintaining growth chart ■ Child cards for children below six (for medical history) ■ Nutrition supplementation ■ Referral of children with 2SD and 3SD malnutrition to the PHC ■ Non-formal pre-school education ■ Health and nutrition education ■ Elicit community support and participation in running the program ■ Assist PHC staff in immunization of children (means motivating mothers to bring children, and mobilizing all 0-6 year olds) ■ House visits to ensure right feeding practices and attendance at AWC	**Child health** ■ Identify malnutrition among children (0-5) and manage or refer to PHC ■ Provide ORS to children with diarrhea ■ IFA to infants and young children ■ Vitamin A solution ■ Immunization ■ Weigh and examine newborn as soon as possible after birth ■ Health Education
Maternal health ■ Nutrition supplement to sub-sect of all pregnant and lactating women (BPL) ■ Enable all pregnant and lactating mothers to collect at the AWC for ANM visit	**Maternal health** ■ Register and provide care to all pregnant women throughout pregnancy ■ Urine and Hb test, BP and three abdominal examinations ■ Refer and facilitate complications ■ Conduct three postnatal visits ■ Health education

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DWCD Interventions	DHFW Interventions
Other women's health issues	**Other women's health issues:** ■ Family planning motivation ■ Distribution of contraceptives ■ Referral for IUD or terminal methods ■ Follow up of users for side effects ■ RTI/STI education, recognition, and referral ■ Minor ailments treatment/referral

Proposed convergence recommendations for women and children's health

Currently the AWC functions as a center for children (0-6years) where nutrition and health services are being provided. In order to formalize this arrangement, the following are proposed:

- The AWC to serve as the focal point for all health and nutrition services.
- As part of the NRHM, a fixed health day is proposed to be held every month at the AWC to provide antenatal, postnatal, family planning and child health services. An ANM and a Medical officer from the PHC will be in attendance. AWW and ASHA (and other community volunteers) be responsible for ensuring that all children 0-6 and children for immunization and other health services are brought to the AWC on a fixed day, when ANM and MO visit to provide immunization, and other health care services. Services to be provided on the Health Day (by the ANM or PHC MO) include: ANC, newborn check up, postnatal care, immunization of mothers and children, IFA and vitamin A administration, growth monitoring, treatment for minor ailments, and health education.
- AWW and ASHA to mobilize women and children, with support from SHG and other community groups, to access services through a fixed health day held every month at the AWC.
- AWW and ASHA to counsel women for institutional deliveries and facilitate referral (mapping of facilities, help in accessing transport through community SHGs, referral slips).
- AWW and/or ASHA to be present at all home deliveries (as second attendant) to provide care and advice for the newborn. This includes: weighing the newborn at birth (or within 48 hours), safe newborn care and practices, warmth, early breastfeeding, and identification of sickness.
- AWW and ASHA could motivate newly married women and recently delivered women to use family planning. The AWC would serve as the depot for pills and condoms (social marketing could be considered) and the AWW and ASHA would also facilitate referral for other methods.
- The AWW and ASHA would participate in routine immunization and special campaigns like Pulse Polio through social mobilization.
- Vitamin A: the first two doses are given in conjunction with measles and the first DPT booster can be administered by the AWW under the direct supervision of the ANM on the Monthly Health Day. Thereafter, the remaining three doses could be given by the AWW herself.
- AWW and ASHA to work with communities and Village Health Committee to promote cultivation of green leafy vegetables, and ensure that these are supplied to the AWC on a regular basis to improve micronutrient content of food supplements.

- Facilitate referral to appropriate health facilities, particularly for institutional deliveries, RTI/STI, violence, abortion, and gynecological and other morbidity.

Next steps

- Review job descriptions of the AWW, ANM, and ASHA and ensure that roles and responsibilities for convergence are clearly defined.
- Examine training curriculum of AWW and ASHA and ensure that newer areas such as newborn care, vitamin A administration, IMNCI, and their role in IMR and NMR reduction is highlighted.
- Examine contents of drug kits of AWW and ASHA and ensure that a drug kit for minor aliments, in keeping with rational drug use, is available at the village level.
- Joint training of ANM, AWW, and ASHA on key technical areas as well as on roles and responsibilities with reference to convergence.
- Short in-service course for AWW/ASHA on newborn care and sick child referral.

2.4.3.3 How to bring about and manage convergence?

An institutional mechanism will be established that will meet regularly to stimulate, steer and monitor the process of convergence. There will be:

- A Convergence Policy Group
- A Convergence Working Group

This is in addition to joint working groups proposed for NACP and WCD.

The Convergence policy group

This group will recommend the policy framework for the working group. The Secretary, Planning Commission may chair the Policy Group and its members may include Secretaries from the following departments:

- Health and Family Welfare
- Woman and Child development
- Rural Development
- Urban Development
- North East Development
- Elementary Education
- Youth affairs and Sports
- PD NACO / Additional Secretary H&FW (also designated as the convener)

The broad terms of reference for the policy group may be:

- To identify the areas of convergence.
- To work towards convergence in a synergistic way.
- To identify the institutional mechanisms required at State and district levels to operationalize convergent working.

- Define resource sharing and responsibility areas.
- Phase convergent areas over the time span of three years, beginning with the priority areas. Agree on priority areas and timeframe.
- Define responsibility of each ministry.
- Ministries agree to second a senior official to the working group.

The convergence working group

This group will meet once a quarter for half a day at a venue selected exclusively for this purpose. The meetings of this group may be co-chaired by the Jt. Secretaries of Health and Family Welfare. Joint secretaries of the related ministries of RD, UD, WCD, North East Development, Department of Elementary Education, Youth Affairs and Sports as well as the Project Director NACO may form the rest of the working group. To facilitate the conduct of these meetings and also to enable the group to reach agreements on points of coordination, assessment indicators and monitoring with special reference to RCH Phase II focusing on EAG States, the work of the group may be facilitated by a consultant (with experience in administration in the social sector). This consultancy support may be provided with the assistance of the WHO/ DFID or the World Bank.

The terms of reference for this group may be to:

- Establish working mechanisms at State and district levels.
- Carry out joint convergence planning while drawing up annual plans.
- Identify modalities of work in specific areas.
- Assign responsibilities for lead areas to make the convergence possible among the different departments.
- Encourage States to develop structures to make convergence operational.
- Approve the roles and responsibilities of the staff at the operational level so as to formally operationalize convergence.
- Designate areas to be piloted by lead departments within a given timeframe in order to take inter-sectoral convergence forward.
- Identify technical and attitude training needs for different levels of staff.
- Share the training load in the lead areas so that providers have sufficient skills and capacity to carry out work.
- Monitor and review progress in inter-sectoral coordination.

2.4.4 Donor convergence

All development partners contributing their funds to the RCH Phase II funding pool will execute a MoU to cover technical, operational and financial cooperation among the organization. All development partners (whether contributing to the pool or not) will execute a MoU to cover technical, programmatic and reporting cooperation among the organizations.

3

Strengthening Systems and Partnerships

This chapter of the Reproductive and Child Health Phase II Program is an important part of the program implementation plan. It discusses how the systems could be improved and partnerships could be strengthened by the states and districts. It focuses on issues like behavioral change communication, public private partnerships, NGO participation, strengthening of infrastructure, procurement, training and monitoring, information and evaluation framework.

3.1 Behavior Change Communication (BCC)

3.1.1 Introduction

Traditional IEC methods stop at giving information and creating awareness but BCC is characterized by its *direct approach to changing behavior*. This means that there exits an understanding that it is not enough to just give information and raise awareness about a health issue. Direct messages that relate to an identified desired behavior must be conveyed in a variety of ways.

A carefully planned and managed BCC strategy ensures that the behavior identified for change is feasible within the social and cultural context in which people live. The starting point, therefore, is research to identify current behaviors and the context in which they take place.

Two principles are paramount:

- Behaviors must be adoptable in the context of peoples' lives.
- Behaviors must be amenable to change.

The RCH Phase II will lose credibility if it exhorts people to do things they are unable to do (such as use contraceptives that are not available). At the same time, BCC activities may be used to provide the cues for a community to press for changes to improve service provision, thus beginning the process of producing "active consumers" of health care services.

A BCC strategy must also address ways in which messages are given and the means of delivery. The RCH Phase II BCC strategy advocates using "multi-channel" activities, various mass media channels of communication (television, radio, print, for example) and more localized "folk" media as well as reinforcing messages by inter-personal communication (IPC) methods. The purpose of IPC is to speak directly to individuals and small groups with empathy and respect; thus reinforcing BCC by increasing its relevance in everyday life. The RCH Phase II BCC strategy will be professionally developed and involve strategic partnerships with the private sector.

In summary - BCC must be:

- Research based
- Client centered
- Benefit oriented
- Service linked
- Professionally developed
- Linked to behavior change

3.1.2 Some success stories

- **Goli Ki Hamjoli** was an effort to expand oral contraceptive use in urban settings. BCC was aimed at stimulating demand, neutralizing negative attitudes, orienting pharmacists and encouraging manufacturers to widen distribution. A combination of advertising, public relations, outreach, direct contact and advocacy for policy change over a period of five years led to an increase in the daily use of pills from 6% to 11%.
- **SIFPSA's tetanus toxoid campaign** in UP demonstrates how results can be achieved on a substantial scale even under circumstances that are not conducive to behavioral change. SIFPSA and the State Government developed a communication strategy to encourage some 2.5 million pregnant women across the entire state to take two doses of tetanus toxoid (TT). A combination of mass media, local media and home visits covered 100,000 villages and 700 urban centers. In two years, the proportion of pregnant women receiving two doses of TT increased from 33% to 68%. An important factor in this success was the role played by NGOs.
- **GoI's polio eradication campaign** is a good example of a communication strategy and media pressure to reinforce existing behavior. In order to achieve the national goal of eliminating polio by 2005, a saturation campaign has been adopted. All mass media, a wide range of local media and social mobilization methods have been used to create word-of-mouth support and encourage parents to bring their children to immunization centers. India's most widely recognized movie star, Amitabh Bachchan, has become a spokesperson for the campaign.
- **PSI's Balbir Pasha HIV/AIDS campaign** in Mumbai shows that BCC can be successful even if the topic is difficult to address in public and the audience does not adequately recognize the problem. The campaign aimed at increasing awareness of risk among men, by generating word-of-mouth discussion and encouraging men to seek Voluntary Counseling and Testing (VCT) services. The strategy consisted of integrating mass media, local media, an HIV/AIDS helpline and VCT services. Despite objections to the directness of the messages, results were very impressive: The proportion of men visiting commercial sex workers who were aware that they were at high risk of HIV if they had unprotected sex with a non-

commercial partner increased from 17% to 43%. Reported condom use on visit to a commercial sex worker rose from 87% to 92%.

- The **Janani social franchising program in Bihar and Jharkhand** is a good example of communication strategy being used to support the social marketing of a range of services rather than products. Rural medical practitioners were trained to conduct simple tests, such as those for pregnancy and blood pressure, and franchised as a "Titli" (butterfly) center. Since pills and condoms are low profit margin items and unattractive to retailers in rural areas, Janani bundles them with a profitable basket of services and requires franchisees to carry the full range of services. In urban areas doctors undergo training and run "Surya" clinics primarily offering family planning services, including medical termination of pregnancy (MTP). In the last three years, the program has delivered 1.2 million Couple Years of Protection (CYP), 15% of the total CYP.

3.1.3 Best practices

- **Branding** means much more than just having a logo; it should ensure that all parts of the program are unified. "Reproductive and Child Health" says little, if anything, to the general population. A brand should relate to what is being offered to the consumer and provide a promise. It must be visible in BCC materials, on uniforms of workers, equipment and vehicles, banners and wall paintings. In short, it should be attached to everything related to the program. Having a logo is part of the branding of RCH Phase II. The logo should be simple, easily identifiable and should convey the message that RCH Phase II is about the health of all women, men and children as well as the future of India.
- **Constant media pressure** is a feature common to all successful public and private programs. A limited number of BCC messages must be presented regularly and in different ways so that the audience becomes familiar with the issues and begins to internalize them. The more simple the message, the easier it is to remember. Messages broadcast on TV or radio need to be reinforced, for example, in print, at health *melas*, on the walls of the health center and by health providers during talks and consultations.
- **Multiple influences and influencers** are needed to make BCC strategies effective. For example, mothers-in-law are known to influence the birth spacing behavior of newly married couples, especially in rural areas. They also play a significant role in pregnancy, delivery and infant nutrition, perhaps discouraging immediate and exclusive breastfeeding. However, having said that, mothers-in-law can be an important target group for BCC for young mothers.
- **Combining professional skills with contextual understanding** will enhance the chances of success. A partnership between the private sector, with its experience and expertise in both social and commercial marketing, and service providers who have knowledge of the social and cultural determinants and constraints on health-related behavior, is essential for the success of the case studies above.
- **Understanding that changing behavior takes time**. The experience of the HIV epidemic shows that even where there are financial resources, strong political will and clear evidence that certain behaviors are dangerous, it still takes time to change behavior. The social context of BCC in RCH Phase II includes issues such as gender, beliefs about health and illness, sexual and reproductive health matters, family and caste relations. Deeply rooted values are not easy to change.

3.1.4 The strategic approach

Role of Behavior Change Communication in RCH Phase II

The core objective of BCC in the RCH Phase II program will be to "encourage individuals, families and communities to make informed decisions concerning reproductive and child health through a program of health communication which facilitates behavior change". BCC as a strategy will be positioned to encourage behaviors that are doable in the context in which people live and are also amenable to change.

In the RCH Phase II program, it is vital that BCC itself is understood in the right context. BCC is dynamic process which involves an understanding of capacity, sharing of ideas, information, attitudes, beliefs, myths and removal of misconceptions and wrong practices. Hence, the BCC component in RCH Phase II will be characterized by its direct approach to changing behavior.

Any BCC strategy for RCH Phase II will have to operate in a framework of stages. People usually move through several intermediate steps in the behavior change process. In addition, there is typically a correlation between increase in behaviors, such as partner-to-partner dialogue about reproductive health and subsequent use of reproductive health methods. The transformation in stages would involve the following: receiving information, processing/ understanding the received information, changing health behavior and finally health seeking behavior level.

People at different stages constitute distinct audiences. Thus, they usually need different messages and sometimes different approaches, such as interpersonal communication, group communications and mass media.

An audience can generally be described as:

- Pre-knowledgeable – unaware of the problem or of their personal risk.
- Knowledgeable – aware of the problem and knowledgeable about desired behaviors.
- Approving – in favor of the desired behaviors.
- Intending – intends to personally take desired action.
- Practicing – practices the desired behaviors.
- Advocating – practices the desired behaviors and advocates them to others.

Once a community attains the stage of health-seeking behavior, the demand factor sets in. Demand for quality of care in health services and information are the most natural outcome of this stage. This further strengthens BCC and service provider chain, and also acts as a strong catalyst.

Under the direct approach, the BCC strategy would utilize multiple channels to transmit and reinforce messages that address well-defined target groups to change their current behavior. This is done by providing skills, tools and human resources leading to better maternal and child health. It also means creating a supportive environment that helps people adopt and maintain the desired behavior for better health outcomes. BCC is thus a process that promotes positive change in individuals and the environment.

The BCC RCH Phase I Experience

Since the inception of RCH Phase I, the BCC interventions have not been able to produce desired results due to the absence of an integrated strategy on communication needs and assessment. What needs to be done in RCH Phase II is to integrate India's communication environment into the health system with

the needs of the people and awareness about availability of services. This would lead to the health-seeking behavior of the people.

Unlike RCH Phase I which did not have any systematic format for monitoring and evaluation, the RCH Phase II BCC strategy would have defined parameters to evaluate and study the impact assessment of the given interventions. Under RCH Phase II, budgeting would not be based on expenditure, but rather it would be based on what it would take to bring about change in performance indicators. The content creation and management of messages in RCH Phase II under behavior change communication would be motivational rather than prescriptive.

The experience of RCH Phase I reveals very little media planning in terms of positioning tools for intervention. Under the RCH Phase II program, each BCC component would have performance variables and indicators attached for evaluating impact. Each intervention would be evaluated by performance indicators linked to behavior change.

Basic BCC framework for RCH Phase II

A basic BCC framework is mandatory in creating an enabling environment to support new health seeking behaviors. Nonetheless, this framework is dependent on certain stages. These are:

- Analysis – Understand the nature of health issues and barriers to change. This is extremely important in a diverse country like India. The analysis factor has to be studied at length in the health management system. Key issues to be addressed include assessing the existing communication resources, evaluating program policies and the ability to listen to potential audiences in RCH Phase II.
- Strategic design – Identification of the objectives and the audience segments, selecting channels of communication, designing for evaluation and strategizing interpersonal communication plans.
- Development of content inclusive of production, revision and pre-testing. This is a dynamic process which would change according to progress in the RCH Phase II framework.
- Management, implementation and monitoring – Mobilize key organizations; creating a positive organizational climate, implementing action plans and monitor dissemination and output impact.
- Impact evaluation – Measure impact on audiences with feedback mechanism.
- Planning for continuity and sustainability – As RCH Phase II will be a long-term program, it will be important to create a framework which allows the BCC strategy to adapt to the changing conditions.

Strategic BCC inputs in RCH Phase II

In order to have effective interventions under BCC, key strategic inputs would involve:

- Client centered approach
- Behavior linked services and delivery system
- Advocacy interventions based on normative research
- Public-private partnership for social mobilization
- Capacity building initiatives for new role and responsibilities
- Decentralization and accountability based on performance indicators
- Synergy of interpersonal communication tools with mass media application and content management
- Linked involvement with field based media units of the Information and Broadcasting Ministry

- Enhanced role of professional procedures, partners, processes and use of marketing approaches in communication

Key themes for BCC interventions under RCH Phase II

The term "reproductive and child health" covers a wide range of health behaviors and services. Therefore, a wide range of key issues would need to be addressed, including maternal health, child health, neo-natal health care, immunization, role of village health workers, unmet needs of contraception, spacing methods, adolescent health and nutrition needs, age at marriage, breastfeeding etc. However, one fundamental learning has been that behavior change strategies – as distinct from the IEC strategies used in the past – can be successful only if they focus on a short list of things, limiting the areas of behavioral change to ensure application of concentrated and sustained attention and resources. Therefore, the proposed approach for BCC in RCH Phase II is necessarily selective. It does not aim to promote and advocate behavioral change across the wide range of possible health and social topics that could be included.

Three areas have been given priority, based on the impact they are likely to have on the levels of mortality and morbidity of women and children in terms of reproductive health. Within these three proposed areas, there has to be further selection of the most important behaviors which will bring change.

The focus on the three areas and their inter-linked behavior allows more rational and controlled use of both financial and human resources. The approach has a phased plan, which gradually shifts attention and behavior from more aware and altered health behavior to a position where individuals and communities become active consumers of safe health care in both the public and private sectors.

Identifying three priority areas does not mean that other issues will not receive communication support. It simply means that behavioral change in these areas will be considered essential to achieving success in RCH Phase II.

The three priority areas for this BCC strategy include lowering the maternal mortality ratio (MMR), the infant mortality rate (IMR) and stabilizing the total fertility rate (TFR). Provision for state-specific priorities will be made as deemed necessary.

Identification of these areas has been done on the basis of the Millennium Development Goals, India's priorities as stated in the Tenth Five Year Plan and the medium term goals of the country's National Population Policy.

For each priority area, the BCC strategy would develop a limited, but very focused, set of messages, so that the target groups, service providers and the community in general are clear about the desired behaviors:

MMR

- Recognizing signs indicating obstetric emergency and knowing what to do
- Ensuring skilled attendants or institutional delivery
- The importance of post-partum care, recognizing danger signs and knowing what to do

TFR

- Spacing methods
- Delaying age of marriage
- Reducing gender bias

IMR

- Care of the newborn – early and exclusive breastfeeding, keeping it warm and clean, recognizing danger signs
- Immunization
- Care of the sick child – Acute respiratory infection (ARI) and diarrhea

A further key area of behavioral change recommended in this strategy is to promote change among service providers. The objective here would be to encourage providers to be more caring and client-centered in delivering services.

Target areas

The target areas in RCH Phase II would be vital for determining the mainstreaming of the BCC strategy. The BCC strategy would focus on those areas where indicators have to be improved in order to achieve the scale of National Indicators as outlined in the National Family Health Survey (NFHS) I & II and RCH survey data. In a study conducted on BCC in RCH Phase II, geography has been considered as a base indicator for according priority to target areas. According to the report, "This will allow the matching of media (and costs) with the priority in which impact and behavioral outcomes are being sought." Broadly speaking, the target areas are:

- Empowered action group states
- North-eastern states and Assam
- Urban slums facing crisis due to inward migration

Priority target groups

Priority Target Groups are extremely important as they constitute the core of all strategic decision making. In BCC under RCH Phase II all the interventions will be aimed at these groups. Some of the groups include:

- Service providers in the public and private sector
- Panchayat, religious and other village leaders
- Mothers-in-law
- Adolescents
- Couples with one or more children
- Couples wishing to have no more children

Secondary target groups

- Key functionaries and stake holders in related departments
- District level functionaries
- Media functionaries
- Corporations for BCC communication in urban areas

Communication strategy

Under the BCC component of RCH Phase II, there will be strong emphasis on evidence-based media planning. This is important to assess the feasibility of a given media intervention under the RCH Phase II framework. In order to achieve the above objective, the parameters have already been outlined in the

basic BCC framework and strategic BCC inputs mentioned earlier in the report. It may be also mentioned that the Department has begun the task of assessing interventions through impact assessment mechanisms. Currently, this is being done in the case of television.

A common feature of the good practice cases found in BCC in India has been the use of a combination of mass media, social mobilization and interpersonal communication (IPC). Such a strategy relies heavily on the use of such multiple channels. Experience in communication suggests that mass media by itself is rarely effective in changing attitudes or behavior. However, when used in conjunction with social mobilization and tactics aimed at generating word-of-mouth discussion, such media are very effective in context setting and reinforcing behavior. Such a strategy will use communication to service providers in a planned manner to strengthen the IPC.

This communication strategy will, as mentioned earlier, treat service providers as a distinct target group. Messages will be planned and delivered using a set of appropriate channels. Group meetings, personalized letters from their seniors, newsletters and events (contests, festivals etc.) would be examples of such channels. As with the communication plans for the 'external' community, internal communication would be timed and placed in different media to generate synergy and maximize impact.

Communication framework and tools under BCC

Every BCC strategy has to include a basic communication framework, which outlines the channels and tools for intervention. Under RCH Phase II, the tools and channels mentioned below would be used extensively in the media plans. The tools and channels will be positioned according to the capacity of the state and the media requirements. This is a dynamic process and changes in the intervention strategy would take place as and when required.

The purpose of highlighting specific tools and channels is to synthesize, collate and disseminate information on the merit of each aspect of media intervention.

A communication strategy comprises of a bag of tools or a toolkit to choose from. The challenge is to choose the best combination of tools to follow the strategic approach and achieve the objectives.

- Advocacy: A set of tools used to create a shift in public opinion and mobilize necessary resources and forces to support an issue.
- Advertising: A set of tools to inform and persuade in a controlled setting through paid media, such as television, radio, billboards, newspapers, and magazines.
- IPC enhancement: A set of tools that can enhance personal interaction between clients and providers, including discussions within and outside the clinic. It includes not only training of the information providers, but also enhancing the place where the communication takes place.
- Community participation: A set of tools meant to help a community to actively support and facilitate the adoption of a desired behavior.

Interpersonal channels which include one-to-one communication, such as provider to client, spouse to spouse, or peer to peer.

Community-based channels, which reach a community (a group of people within a distinct geographic area, such as a village or neighborhood, or a group based on common interests or characteristics, such as ethnicity or occupational status). Forms of community communication are:

- Community-based media, such as local newspapers, radio stations, bulletin boards and posters.
- Community-based activities, such as health fairs, folk theatre, concerts, rallies and parades.

- Community mobilization, a participatory process of communities identifying and taking action on shared concerns.

Relationship Between Channels and Tools Under BCC

Channels	Tools Used on the Channels	Materials / Activities
Interpersonal Communication (IPC)	Peer Counseling	Training, support materials
	Provider Counseling	Training, support materials
	Health Clinic Enhancement Mahila Swasthya Sangh Groups	Posters, pamphlets, videos used by client without personal interaction with provider.
Community Channels	Community Participation	Group meetings, guides, rallies, advocacy activities, speaker kits, press kits.
	Community Media	Community newspapers, local radio, hoardings, criers, mikes.
	Community Activities	Folk drama, road shows, health fairs.
Mass Media T.V., Radio, Newspapers, Magazines, Billboards, Transit cards exhibition, Bus back panels	Advertising	Print advertisements, TV spots, radio spots, outdoor posters, transit cards, mobile publicity
Mass Media T.V., Radio, Newspapers, Magazines, Billboards, Transit	Publicity	Press releases, video releases, articles, radio press releases, press conference, public service announcements, journalist training, exhibitions.
Media, Community, Interpersonal	Advocacy	Kits containing pertinent facts and compelling stories to garner support for a policy, issue, or constituency; meeting; mailings.
Media, Community, Interpersonal	Promotion	Coupons, free samples, contests, sweepstakes, either through media or at community and store level.
Media, Community	Event creation and sponsorship	News conferences, celebrity appearances, grand openings, parades, concerts, award ceremonies, research presentation, sporting events.
Media, Community	Entertainment education vehicles	TV programs, radio programs, folk drama, songs, games, field exhibitions, interactive programs

Implementation strategy

Branding RCH

Giving the RCH program greater salience and increased visibility will be a key feature of the implementation strategy. It is planned that the RCH program be "branded." By "brand" we do not mean just a name or a logo or a set of graphics or sounds. A brand is a name and a symbolic (visual and/or audio) depiction of a

product, service, program or organization. Along with the physical representation, the brand also captures a set of psychological associations that the audience is expected to attach to the name and symbol. Together, the physical and psychological aspects of the brand should represent the core idea – what the brand offers, who it is meant for and how the audience should relate to it. Keeping in mind the priorities outlined for RCH, our intention is that the branding of RCH program be based on the thought,

"Our Health...Our Future"

Research will have to test possible visual symbols for the brand so that it transcends language and literacy (ensuring that "our" is visually translated to show a family). How non-literates understand and relate to the brand could be a key factor in the success of the overall communication strategy. Once adopted, the RCH brand should be all pervasive – it should be carried in all communication, at all events, on all facilities (SCs, PHCs), equipment (including vehicles) and supplies (staff uniforms, bags, etc.). Since substantial use of radio is visualized, it would be necessary to have a 'signature sound' that becomes a distinctive and recognizable feature of the brand. Managing the visibility while retaining the 'personality' of the brand will be a key management task.

- The concept of branding would serve the purpose of providing an anchor to which all aspects of the BCC strategy and its implementation would correlate. It would become a mantra which everybody knows.
- BCC media plan would outline multi channel inputs to maintain constant media pressure. In RCH Phase I, the effectiveness of interventions was limited at times because of lack of constant pressure in message dissemination. In RCH Phase II under the BCC strategy, the media plan would be devised to ensure that the messages are short and the audience gets an opportunity to internalize them.
- The BCC strategy would mainstream the role of multiple influences and influencers in the social environment. For example, highlighting the role of mothers in child development and the influence of mothers-in-law and peer in decision making in rural areas in the context of family planning and preference for male child.
- The widened role of professional expertise and skills in BCC management. To ensure better program management in this regard, partnership with agencies would be an asset in areas concerning media planning and monitoring.

Implementation

A. Organization

- Central level

The Organizational arrangements for implementing BCC strategy will:

- Coordinate with other units for positioning themes/ issues related to other divisions of the RCH Phase II.
- Strengthen the central BCC unit's capacity;
- Timely implementation of the BCC strategy and activities.

The BCC unit for the RCH Phase II will be located in the existing IEC Division of the Ministry of Health and Family Welfare (MoH&FW). The Department of Family Welfare (DoH&FW) will be named as a BCC Division and the Director/DS (IEC) will be responsible to the program management unit for the BCC strategy. The

DFID report referred to earlier, recommended that in view of the demands of the RCH program's BCC, a separate BCC unit be constituted within the IEC Division with eight new staff members:

- Strategy development (1 person)
- Media planning and operations (1 person)
- Research and Analysis (1 person)
- Field operations ~ non-mass media activities (4 persons)
- Internal communication management and logistics (1 person)

The creative work would be contracted to private sector partners. The task of the BCC unit would be to ensure that the brief for these partners fits the strategy and can be carefully monitored and evaluated.

In order to ensure that the strategy benefits from the experience of external experts, it is proposed to constitute a BCC Management Board. The Board would provide technical inputs on communication strategy and management and would support the BCC Division Director in executing his/her BCC responsibility to the PMU. The Board, not exceeding five members, could consist of representatives from UNICEF, SIFPSA and experienced NGOs such as PSI or Janani, provided the latter are willing to be excluded from bidding for any contracts under this program.

In implementing the BCC strategy it will be most important to create synergy with other agencies working in the area of reproductive health to ensure that messages are consistent and reinforce each other. A close partnership with National AIDS Control Organization (NACO) is visualized.

Components of the new framework

The changing attributes of the BCC strategy for RCH Phase II within the country will require a change in responsibilities for BCC actions at the central, state and district levels. The Central Government would steer the BCC intervention plan by balancing the BCC capacities of the states within the overall program objectives of RCH Phase II.

States will assume greater responsibility in addressing state specific societal behavior norms as well as for planning support for district-based efforts in IPC and local publicity. Districts will become the natural focus for convergence of government and non-governmental efforts for behavior change through participatory planning and inter-personal communication. They will also assume the lead in initiating local (rural and small town) publicity efforts within the context of RCH objectives and goals.

The central, state and district administrations will perform complementary roles within the IEC to permit service providers and frontline workers to achieve their goal of delivery of demand driven, quality RCH Phase II services.

Responsibilities of the center

The center will take responsibility for the overall strategy development process for BCC within RCH Phase II, with the full involvement of and coordination with state administrations. The center will oversee and monitor BCC actions undertaken by the states and also track their impact.

- Undertake concerted communication campaigns on the priority areas described earlier.
- Bring together national expertise from government, voluntary and private sectors in the areas of research studies, training, health care, advocacy and management support.
- Enhance the capabilities of relevant staff within the central ministry.

Responsibilities of states

States will take charge of an important BCC activity. They will be responsible for facilitating BCC actions by districts and self-governing urban communities. The development of state plans would be based on areas of priority identified under BCC in the RCH Phase II framework. The focus areas described in the plans submitted by 15 states are in convergence with the priority areas identified for the central BCC strategy. Where there are state-specific needs (e.g., Tamil Nadu's proposed social mobilization against female infanticide and feticide or Maharashtra's specific activities for the age group above 40 years), provision will be made to support local plans. In all other cases, states will be asked to draw detailed plans for local and interpersonal communication in support of the nationally managed theme campaigns.

The states will monitor actions undertaken by them and track the effects of such actions on the changing picture in response to delivery of RCH Phase II services and communication efforts. This will be a part of the BCC monitoring framework under RCH Phase II. Other responsibilities would include:

- Drawing together state-local expertise from government and non-government sectors in the areas of research studies, training, health care, advocacy and management support.
- Enhance the capabilities of relevant staff within the state.

The state will thus become the hub of specific campaigns to address the communications need of its populace. The plan will be backed by the development of capacity to undertake supportive supervision and monitoring, and to support production of materials which address the specific need of the state.

Organization

For a proper and effective BCC intervention, states would have to adapt to the new environment. As we are all aware, the media environment and tools have changed dramatically. In RCH Phase II, under the BCC component, states will have to adapt to new themes, tools and strategies in order to induce health-seeking behavior amongst the masses.

In the release of budgetary allocation to the states, the BCC Division at the center introduced the concept of performance-based indicators for fund release. At the same time, a working group on the restructuring of BCC Bureau in states has been constituted to implement a common organizational structure across the country at the state and district levels. Under RCH Phase II, states will be expected to implement the recommendations of the Working Group headed by Deputy Secretary (BCC) of the DoH&FW. The Working Group was constituted under the directions of Secretary (Family Welfare) with a view to have an IEC/BCC organizational structure at the state and district level in all the states and Union Territories.

Responsibilities of districts

The changed responsibilities for BCC at the district-level will enable frontline workers to respond to identified RCH needs of individuals within the community, facilitating the use of community specific, local knowledge and practices to promote behavior change. They will actively work to influence the normative behavior of local communities (including small urban communities) through the involvement of local self-government and opinion leaders within the area.

The action plan of districts will incorporate:

- Dissemination of information sensitization and awareness building
- Utilization of folk media and other local channels of communication
- Convergence of the efforts of related departments

- Enhancement of the capabilities of relevant staff within the district

The district will thus be the central point for the development of an appropriate and flexible action plan to support the communication needs of the community. The plan will be backed by the development of capacity to undertake supportive supervision and monitoring, and simple tracking techniques to assess progressive change in the knowledge, attitudes, beliefs and practices (KAPB) among the communities.

Phasing and monitoring

A key feature of the BCC strategy is that it has to be implemented in a phased manner. The themes, priorities and deliverables will be benchmarked to study and monitor performance indicators. Behavior change will be judged according to a set of indicators which will constitute the evaluation matrix. The core of this matrix will be channels of communication adopted for BCC. Priority themes will be decided on the basis of the recommendations of the technical team and the capacity to implement the plan in the case of states.

Internal communication will constitute the key intervention points for BCC. This could apply to both the center and the states. The objective is to acquaint the key stakeholders with the broad RCH Phase II Mission objectives.

An important consideration in deciding the phasing is that the services must be in place (if the behavior is dependent on them) and that neither individuals nor communities can deal with too many changes at any one time. Therefore, communication strategies must focus on a limited set of behavioral changes at a time and, secondly, they should follow (not be independent of) the availability of quality services.

During Year 1:

- The new BCC Unit will be set up and existing staff trained
- A baseline on service providers is set up (including data base containing names, locations) to assess supply side
- An internal communications package (for service providers and others connected with the RCH program) is designed and implemented
- Private sector partners are contracted
- Formative research on behavior areas is completed and monitoring system installed
- The first major communication plan for a behavioral change area, on gender bias, is designed and implemented. This is because changing attitudes and behavior in this domain do not depend on service delivery.

In two to five years, other topics will be included in the program in a planned and phased manner. It is planned that communication aimed at changing behavior at home (e.g., delaying age of marriage) starts early in the phase to ensure that it can run for a maximum period over the four years.

BCC Implementation Plan Under RCH Phase II

S.No.	Activities	Year-I				Year-II			
		Q-1	Q-2	Q-3	Q-4	Q-1	Q-2	Q-3	Q4
1.									
2.	(a) Set up new BCC unit (b) Train existing staff								
3.	Development of (i) Baseline on service providers (ii) Package of internal communication								
4.	Contract private sector partners								
5.	(a) Design and complete formative research (b) Install monitoring system								
6.	Design and implement campaign on reducing on maternal and child health								
7.	Design and implement campaign on delaying age of marriage, spacing methods								
8.	Design and implement campaign on Adolescent Health, nutrition needs and Reproductive Health								
9.	Evaluation of the activities and monitoring indicators/ TORs								
10.	MIS of key stake holders development and design								
11.	Review mechanism								

Illustrative budgetary allocation for BCC activities under RCH Phase II

The IEC Division proposes to allocate budgetary support to the following sectors. These sectors incorporate a wide range of activities focusing on priority themes /areas identified by the Department.

	Sector	Allocation (In Crores)	% age
(a)	Focused BCC in EAG States	Rs. 51.52	35.54
(b)	Social franchising/brand management of product/services	Rs. 13.60	9.38
(c)	Immunization, Maternal & Child Health, Polio, etc.	Rs. 20.00	13.80
(d)	North-eastern states	Rs. 9.70	6.69
(e)	General BCC	Rs. 50.14	34.59
	TOTAL	**Rs. 144.96**	

Themes

- Maternal and Child Health
- Immunization
- Unmet needs of contraceptives
- Spacing methods
- Breastfeeding
- Age at marriage
- Adolescent Health and nutrition needs
- Role of village health workers
- Neo-natal health care

Core objectives

The core objective of BCC in the RCH Phase II program will be to "encourage individuals, families and communities to make informed decisions concerning reproductive and child health through a program of health communication which facilitates behavior change". BCC as a strategy will be positioned to encourage behaviors that are doable in the context in which people live and are also amenable to change.

3.2 Public-Private Partnerships (PPP)

3.2.1 Need for Public-Private Partnerships

India is a middle income state with a per-capita income of US$440 (World Bank 2001). It spends about 5% of its GDP on healthcare, which is considered a healthy amount. But the concern is that 85% of expenditure on health is out-of-pocket; government contributes only around 1% of GDP for health. To further complicate the issue, only 20 percent of the total expenditure on health is on primary health care.

A significant proportion of the resources spent by the people on healthcare ends up in the unorganized private sector. In many instances, it has been observed that people are unable to gain commensurate professional help for the resources spent for the purpose. One of the primary reasons for this seems to be wide disparities in quality of healthcare services being provided by the private providers.

Another obstacle in making essential RCH services available to the people is a lack of formal insurance system for taking care of healthcare expenditure. Almost the whole of private expenditure is out-of-pocket (unorganized working class) and minuscule amount from insurance (primarily through the organized sector). Most of the time, healthcare needs are unexpected and are not accounted for in the household budget, often leading to debt and even impoverishment.

There is an elaborate system of public health care institutions being financed through the public treasury (i.e. the tax revenues). A majority of these institutions have the potential of providing the complete package of RCH services. But with the existing high unmet need for contraception and maternal and childcare, it seems difficult for the present structure of healthcare to deliver the services, even when functioning in its optimum capacity. The problems are compounded by the underutilization of the existing health infrastructure, as is evident from low occupancy rates in many hospitals, reflecting the low acceptability of the affordable and available public sector healthcare. Despite the presence of an intricate and elaborate system of RCH services, there is a high unmet need for these services. The combination of low CPR and a high unmet need is one of the indicators of the need to improve access to RCH services.

Benefits of public-private partnerships

Public-private partnerships have distinct advantages and help to achieve desired health outcomes. They should not however be considered an end in themselves but a means to achieve specified results. Public-private partnership (PPP) is a specific strategy and several other innovative strategies have to be put in place and pursued with vigor to achieve the overall objectives of RCH Phase II program.

1. *Creating competition:*
   - Competition between the PPP initiatives and other healthcare providers would ensure availability of private facilities to the poor through reduction in costs
   - Greater choice of services would be available to the poor
   - Better quality of services can be achieved by setting up standard guidelines for the initiative participants. Thus a basic minimum level of quality of healthcare services would be maintained. The competing private healthcare providers would try to improve the quality as well, to increase/ retain their clientele.

In other words, through this initiative, the private providers are oriented to compete with the public-sector providers to act as agents for providing public healthcare to the poor.

2. *Economies of scale:* By standardizing the services throughout the initiative, it is possible to achieve cost reduction using economies of scale
3. *Utilizing the existing capacity of the system*: It is thus much faster to implement, as very little infrastructure development needs to be done (in most instances). The effort is to make use of the existing facilities, wherever feasible. The resources saved can be utilized in tending to other aspects of healthcare delivery.
4. *Create synergy* between the public and private systems thereby reducing the duplication of efforts and wastage of funds.
5. *Targeting the poor:* By focusing more on the primary care aspect of the healthcare and making available good quality RCH services at affordable prices, it is possible to provide acceptable and sustainable public healthcare even to the poorest of the poor.
6. *Flexibility in action:* The country can be visualized as passing through a phase of health and demographic transition. But even this transition of health is not uniform throughout the country. While a few states

are in early stages of demographic transition, still having a high birth rate, low utilization of public healthcare etc., other states have already reached replacement level of population growth and have efficient public healthcare delivery services, etc. Thus by developing models involving public-private partnerships taking into cognizance the specific needs of the states, it is possible to address the differences in healthcare needs.

7. The demographic transition has also been accompanied by a *technological revolution* in the country with more and more techniques, instruments and expertise available for healthcare service delivery. Through partnerships, it is possible to provide the public with good quality, high-tech care wherever needed at affordable prices.
8. *Resource mobilizati*on, through philanthropy, donations etc., is easier and more efficient by creating formal channels of private partnerships in providing healthcare.

The initiative intends to achieve the following improvements in the system:

- **Demand side**
  - Better knowledge about the need of RCH services
  - Better information about availability of services
  - Better health-seeking behavior
  - Trust and confidence on healthcare system
- **Supply side**
  - Better quality of health services
  - Standardization of healthcare with minimum standards of care
  - Availability of services to all strata of the society with particular emphasis on poor and disadvantaged.

3.2.2 Objectives of Public-Private Partnerships

- Improving **access** to essential RCH services (i.e. increasing the **penetration** of RCH services in vulnerable and hard-to-reach areas and making affordable RCH services available at all places)
- Improving the **quality** of RCH services available
- Monitoring the **growth of private sector** and directing it towards increasing contribution towards the goal of improving RCH service delivery.
- **Exchange of skills** and expertise between the public and private sector
- **Mobilize additional resources** for RCH activities
- Improve the efficiency in **allocation of resources** i.e. making same services available at lower cost or making better services available at the same cost
- Strengthening the existing health system by improving the **management of health** within the government infrastructure
- Widening the range of services and number of services providers
- Increasing community ownership of the RCH program
- Ensuring optimal utilization of government investment and infrastructure.

3.2.3 Models of Public-Private Partnerships

Various models can be utilized for putting these partnerships into action. Some of the possible mechanisms are:

1. Franchising

A franchise is a type of business model whereby a manufacturer or marketer of a product or service (the franchiser) grants exclusive rights to local independent entrepreneurs (franchisees) to conduct business in a prescribed manner in a certain place over a specified period. Typically the franchiser has developed specialized skills, knowledge, and strategies and thus is able to share its blueprint for a successful product line with the franchisees. The franchisees contribute resources of their own to set up a clinic and pay membership to franchiser.

Partial franchising: Most of the social franchising models followed in India are partial franchising models. A franchiser identifies private hospitals and enters into an agreement with a franchisee to provide certain services in lieu of payment of fee or commissions from sale of services and goods. These contracts largely confine to a basket of RCH services. However, a franchisee provides many other services that are not part of the contract. There is no control over quality of services provided by the franchisee outside the contract.

Usually a one-year subscription fee is given by the franchisee to the franchiser. In this arrangement, increased performance of franchisee does not lead to increased revenues to the franchiser. There is no incentive for the franchiser to improve performance through promotional activities. One way to overcome this problem is to have a revenue sharing arrangement between franchiser and franchisee. However, many of the hospitals are not transparent about their financial transactions, nor do they maintain complete record of services provided.

One of the innovative aspects of these social franchising efforts is to link rural medical practitioners and/or community based organizations such as self-help groups (SHG) with the franchisee. This has helped increase the client load for RCH services. The partial franchising efforts in India do not represent public-private partnerships but offer models and experiences that are highly relevant. Government can have its own model of social franchising with franchiser-franchisee-RMP-CBO linkages. Concentration of private hospitals/ nursing homes in urban areas has to be taken into consideration. In many rural and inaccessible areas where the need for improved access to services is the highest, no private hospitals/nursing homes exist.

Full franchising: The franchisee provides services defined by the franchiser and expansion of range of services depends on mutual agreement. For existing nursing homes and hospitals, this can mean a considerable revenue loss. This has to be compensated by subsidies till the client load improves and the hospitals start making operating profits. Time required for transition of loss making unit to profit making unit depends on a variety of factors such as location of hospitals, demand for services, perceived quality of services and competition. Not many hospitals may opt for this, given the uncertainties in financial returns, unless guarantees are given to sustain the model for a long period of time.

2. Branded clinics

A few organizations have started a chain of branded clinics that offer a wide range of reproductive and child health services. There is scope to expand the range of services provided by these clinics and add social mobilization efforts to their functions. These branded clinics can be opened wherever required with minimum effort. Branded clinics are more sustainable because of their ability to generate more income than the social franchising units.

3. Contracting out

Contracting out refers to a situation in which private providers receive a budget to provide certain services and manage a government health unit. The two parties usually agree on some or all of the following: The quantity and the quality and the duration of the contract.

Common criteria for identifying those government health clinics that need to be contracted out are the first step in this direction. Large number of vacancies for a long period, high absenteeism, and consistent low performance on all RCH indicators could be the critical criteria.

Some states are more willing to outsource services than others. Fear of losing jobs and perceived shrinking role of the government in the health sector are the main reasons for resistance. Advocacy efforts are required in states with high level of resistance to outsourcing services.

There are several levels at which the outsourcing can be done depending on the degrees of freedom given to the contractor. The higher the freedom, the higher should be the performance levels of key RCH indicators.

Option 1: Government hands over the physical infrastructure, equipment, budget and personnel of a health unit to the selected agency.

Option 2: Government hands over the physical infrastructure, equipment, budget but gives freedom to the selected agency to recruit personnel according to their own terms and conditions but following the government norms such as one ANM per 5,000/3,000 population.

Option 3: Government hands over the physical infrastructure, equipment, and budget but gives freedom to the selected agency to have its own service delivery models without following the fixed prescribed pattern.

Option 4: Government hands over the physical infrastructure, equipment, and budget and gives freedom to the select agency to have its own personnel, service delivery models, freedom to expand types of services provided and freedom to introduce user fee and recover some proportion of costs.

4. Contracting in

Contracting in is done for a variety of services in many large hospitals. These include: maintenance of buildings, utilities, housekeeping, meals, medicine stores, diagnostic facilities, transport, security, communications, etc. Hospitals are given freedom to choose the services to be given to contractors. In many cases they lack comprehensive plans or sound financial analysis. Nevertheless, contracting in has resulted in conservation of resources, improved efficiency and better quality of services many hospitals. Contracting in services leads to surplus human resources that need to be transferred to other health units to fill in vacant positions, if any. Resentment of employees and interference of trade unions are some of the major obstacles to this process.

Contracting in for certain type of services does not work in some places. For instance, some state governments were unable to attract private sector participation for diagnostic services in hospitals in remote areas that had a low client load. One option is to subsidize the equipment purchased by private agencies and the other is to make services located in government hospitals open to all. Even a person with prescription from private clinic should be allowed to use privately run diagnostic facilities in government hospitals. This increases the volume of transactions and makes the unit financially viable.

Recruiting doctors, technicians and other staff on a contractual basis for a stipulated period of time is widely practiced in several states. In some cases the contracted staff performs all the duties of the regular

staff and in other instances, their services are contracted for a few days in a month to provide services in a particular clinic. In many states, a large proportion of vacancies is filled this way.

5. Social marketing

One of the earliest efforts at building public-private partnerships was in the area of social marketing of contraceptives. For more than a decade, Hindustan Lever Limited (HLL), Indian Tobacco Company (ITC), Indian Oil and other large FMCG companies helped the government with social marketing of contraceptives by riding piggy back on Nirodh (a brand of condoms) with their products. Subsequently, private social marketing companies emerged as a force to reckon with and gained considerable experience in marketing contraceptive products both socially and commercially. Increasingly, the trend is to enlarge the basket of products by including ORS, IFA tablets, and other health products to make the marketing efforts more self-sustaining. The government provides the subsidized contraceptives, and finances the brand and the point of purchase promotion schemes of selected marketing agencies.

6. Build, operate and transfer

Build, operate and transfer (BOT) models are highly successful in the infrastructure development sector in India. BOT requires part financing of projects by the government, financial guarantees when needed, subsidized land at prime locations and assurance of reasonable returns on investment. These models could be useful to establish large hospitals and ensure quality services at reasonable rates to poor people. However these hospitals should be able to withstand market competition to survive and sustain themselves.

7. Joint venture companies

Joint venture companies are companies launched with equity participation of government and private sector. The proportion of equity of each partner may vary from one venture to another. However, in the commercial sector, most joint venture companies have not succeeded in India due to lack of understanding and trust between the partners, inordinate delays in decision-making and dominance of the government even with low equity. There is an even lower chance of their succeeding in health sector.

8. Voucher system

A voucher is a document that can be exchanged for defined goods or services as a token of payment (tied-cash). This consists of designing, developing and valuing health packages for various common ailments/ conditions (like ANC package / STI package / teen pregnancy package / family planning package, etc.) which can be bought by people at specific intervals of time. These vouchers can then be redeemed for receiving a set of services (like 1-2 consultations, lab tests, procedures, counseling and drugs for the condition) from certified/ accredited hospitals or clinics and are to be used within 2-3 months of buying the voucher. This means that the package can be bought, used as and when required and ensures privacy for the client.

Regular monitoring is required to ensure quality standards and training of health providers. Networking with people is also important to ensure the proper use of vouchers. The vouchers are redeemed at the clinics for the number utilized depending on the price of each package of service provided. Clinics that fail the quality standards of service and do not score high on patient satisfaction can be removed from the certified services list.

9. Donations from individuals

In a large country like India which has substantial high income and middle income groups, there are many examples of private donors willing to partner with the public sector. Rich philanthropists and individual

donations may be the crucial requirement in areas to make the PPP initiative effective in delivering health care. Though in some states mechanisms and provisions are present for utilizing these private donations for improving local health situation, many other states lack these systems. Efforts have to be made to create simple and transparent institutional mechanisms to encourage donations to contribute to the growth and improvement in reproductive and child health services in their area.

10. Partnerships with social clubs and groups (e.g. Rotary club)

Clubs like Rotary and Lions play a significant role in immunization campaigns, Pulse Polio campaign and other health care services. Since these clubs have a nationwide network, their involvement ensures better coverage. They also bring in their expertise and resources to the health care services.

11. Involvement of corporate sector

The corporate sector has a rich history of being supportive of the health and family welfare interventions for people that work in and live around its premises. Under Corporate Social Responsibility, the corporate sector through the Confederation of Indian Industries (CII) and the Federation of Indian Chamber of Commerce and Industries (FICCI) and several other sector wise business and industry associations have played a significant role in advocacy efforts, funding non-government organizations for innovative interventions, introducing new schemes to encourage service utilization and expending their own resources for promotion of reproductive and child health services particularly family planning services.

12. Partnership with professional associations

There are several professional associations such as the Indian Medical Association, Gynecologists Federation, nurses associations, etc. These associations from time to time assist in launching new programs such as Vande Mataram Scheme, Gaon Chalo project and immunization programs like Pulse Polio. They have technical skills and expertise to advise on various other matters including developing standard protocols, quality assurance systems and accreditation. However the managerial capacities of these professional associations have to be strengthened.

Moreover, with widespread chapters/ branches all over the country and huge memberships they can play a very important role in ethical issues.

13. Capacity building of private providers, pharmacists and informal providers (RMPs)

Several initiatives have been taken by the government in the past to improve the technical and counseling skills of private medical practitioners, particularly rural medical practitioners, by providing training to improve the quality of services offered by them. Since they have a huge presence in the rural areas and urban slums and a significant proportion of population depends on them for services, there is a need to involve them in a significant way to create demand for services and to make referral systems effective. Similarly, government medical officers and administrators benefited by participating in training programs conducted by private institutions. Consultancy services offered by private institutions in the areas of communications, systems development, etc. are another example of public-private partnership. Another area of partnership is contracting out management of training institutions such as ANM training centers, regional training centers to NGOs and private agencies.

14. Special "Category Campaigns" with the private sector to improve health

The *WHO-ORS* campaign and the *Goli- ke- Hamjoli* campaigns are examples of the use of the commercial sector to advance national health goals. The category campaigns expand use of a health/family-planning

product, thus increasing the volume and the users for the product. In India, the *Goli ke Hamjoli* and WHO-ORS campaigns succeeded in increasing product awareness, availability, sales, and use. At the same time, this entails using a generic promotional strategy, increased private-sector investment and the value of the market, policy change; coordination with partner pharmaceutical firms; affiliation with professional associations; expansion of market channels; and consumer outreach. Initially, the program should use mass media vehicles to improve product awareness and contemplation. However, as the program develops, the emphasis should shift to encouraging product trials, and the use of interpersonal approaches to reach out to potential consumers.

These special campaigns in partnership with the private sector can focus on the demand generation for refurbished and revitalized public sector, generic promotion of health products (life-saving ORS, menstrual hygiene with sanitary napkins etc.).

15. Autonomous institutions

Giving autonomy to public institutions within the system can lead to improvement in quality, accountability and efficiency. It also ensures greater involvement and ownership at the institutional level, ensuring higher morale and encouragement to the work-force. Many such projects have been implemented and have yielded excellent results, as the need for change in management systems is self-driven. It is also sustainable and easy to replicate.

16. Partnering with CBOs / NGOs

To design and implement innovative approaches for RCH services, partnerships with community-based organizations and non-government organizations are a significant step. For a long time, government encouraged participation of these grassroots organizations in demand creation and delivery of services. These organizations often worked in remote rural areas where access to RCH services was difficult. Recent NGO Policy of the MoH&FW envisages a scheme where each district would have a mother NGO linked to several field NGOs within the district with greater degree of autonomy and decentralization. Community mobilization efforts yield effective results and community ownership of the program is sustainable.

17. Mobile health vans

In geographical areas with difficult terrain with no transport facilities and poor road connectivity, the outreach and institutional services of PHCs are often not up to the expected standards. This has resulted in gross under-utilization of services. To overcome this problem, in some states private sector agencies have taken a lead in launching mobile vans. These vans go to clearly identified central points on fixed days and provide comprehensive health services including RCH services to a cluster of villages. While private sector resources have enabled the purchase of vans, the government has contributed to these services by deputing medical officers and medicines. This approach has significantly helped to improve access to quality services.

18. Insurance and public-private partnerships

In one of the recently planned schemes, the government insures and pays health insurance premium for families below poverty line. These families in turn are insured against expenses on health and hospitalization, up to a certain amount. On similar principle, it is possible to develop sustainable health insurance schemes that are community based. In such schemes, the community members pay a minimum insurance premium

per month and get insured against certain level of health expenditure. This protects them from sudden and unexpected expenditure on health. Such community-based schemes also ensure that the local needs and expectations of the people are met, by preferentially reimbursing local trained healthcare providers.

Classifying PPPs

Since public-private partnerships vary significantly, it is necessary to categorize them in order to understand their nature and thrust areas of partnerships. Some of the partnerships are for a short duration or one time activity while others are for long term. These partnerships also work in specific thrust areas. Some of the partnerships may cover all thrust areas and others one or more.

Nature of PPP	Examples
One Time/Short-term Partnership	Donation of land, money, equipment, etc. Participation in campaigns
Continuous/Long term partnership	Social franchising of service Contracting in and out Social marketing Capacity building

Thrust areas of partnership	Examples
Service-oriented	Social marketing Social franchising Contracting healthcare providers Mobile vans
Information oriented/Advocacy oriented Infrastructure oriented	Contracting out IEC activities to NGOs Category Campaigns with Private Partners
Capacity building oriented	Construction of buildings Repairs to buildings Equipment, Vehicles
	Training for skill development and counseling Systems development Managerial capacity

Criteria for initiating PPPs

Types of public-private partnerships relevant for a particular state depend on prevailing conditions, needs and functional requirements. Some criteria by which the public-private partnerships should be selected are as follows:

Form of Partnership	Criteria for Initiation
1. Franchising	▪ The effort to revitalize the complete government infrastructure is time-consuming and a slow process ▪ Resources required to expand public health infrastructure is enormous ▪ Need for services is enormous and government health institutions are not in a position to cater to needs ▪ Availibility of vast network of private hospitals in places needed ▪ Objective is to improve access to services on immediate basis ▪ Improve quality standards of private sector and provide high quality care at affordable prices
2. Branded Clinics	▪ Need to expand services rapidly ▪ Provide high visibility to clinics ▪ Offer a package of services selected for the purpose ▪ High quality services at affordable prices
3. Contracting Out	▪ Difficult to manage government health units in remote and inaccessible areas ▪ Utilization of services and performance levels are consistently low due to non-availability of staff ▪ Aim is to put government health facilities to optimum use ▪ Increase responsiveness of government health facilities to local needs through community involvement
4. Contracting In	▪ Improve efficiency levels of services provided ▪ Make management of services more effective ▪ Conserve scarce resources by cutting costs ▪ Try out innovative approaches to improve efficiency and effectiveness
5. Social Marketing	▪ Combine service delivery with demand creation ▪ Availability of products in a vast network of easily accessible retail outlets ▪ Encourage brand choices and competition to improve penetration levels ▪ Perceived value attached to priced products than products distributed free of cost
6. Build Operate Transfer (BOT) / Joint Ventures	▪ An enormous number of service delivery points whether hospitals, labs or diagnostic centers have to be constructed within a short span of time ▪ When the cost of building and maintaining a unit is prohibitive for the government to bear alone ▪ When returns on investment are guaranteed ▪ Government treats health as an infrastructure industry
7. Voucher System	▪ Improve access to services and provide choice ▪ Costs act as a major barrier to services ▪ Existing service delivery points do not have provision for all types of services ▪ Inadequate knowledge about the value of service (e.g. importance of ante-natal care) ▪ Generate demand for services particularly among poor and disadvantaged sections
8. Donations from Individuals	▪ Presence of affluent families, philanthropic organizations ▪ Identified needs to improve quality of services ▪ Clear procedures and guidelines to accept donations ▪ Transparent and accountable systems that enhance image of institutions

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Form of Partnership	Criteria for Initiation
9. Partnerships with Social Clubs and Groups (e.g. Rotary Club)	▪ Partnerships to popularize revitalized service points, communication campaigns and logistics management ▪ Organization of camps on a large scale ▪ Need for additional resources and also management and technical expertise ▪ Need to step up advocacy efforts
10. Involvement of Corporate Sector	▪ Resources for outreach services through NGOs in remote areas ▪ Effective services to employees in organized sector ▪ Policy advocacy efforts ▪ Adoption of villages or CHCs/ PHCs by corporate health sector to improve services
11. Partnership with Professional Associations	▪ Presence of active professional associations with clear guidelines ▪ Internal committees to promote ethical practices ▪ Management expertise to implement projects ▪ Need to prepare standard protocols, quality assurance system by building consensus ▪ Improvement of technical skills of professionals in both private and public sectors ▪ Improve professional response to program needs
12. Capacity Building of Private Providers, Pharmacists and Informal Providers (RMPs)	▪ High level of dependence of people on private sector for services ▪ Technical knowledge and skill levels are not to a desirable standard ▪ Improve quality standards of providers and increase access to quality services ▪ Put in place an effective referral system ▪ Involve services providers in social marketing efforts
13. Special "Category Campaigns" with the Private Sector to Improve Health	▪ When the need to promote a service or health care product is established ▪ Multiple partner involvement is required to promote a product ▪ Advocacy efforts to make product acceptable at all levels
14. Autonomous Institutions	▪ Need to upgrade quality of services and initiate use of state-of-the-art technology in health care delivery ▪ Provide enough flexibility to health units ▪ Improve efficiency and effective levels of management ▪ Reduce costs and facilitate quicker decision-making ▪ Allow institutions to generate alternate sources of funding
15. Partnering with NGOs/CBOs	▪ Encourage community involvement ▪ Improve community ownership of program ▪ Test innovative and cost-effective approaches to service delivery ▪ Cover inaccessible and remote areas
16. Mobile Clinics	▪ Provide access to services to people living in inaccessible terrains ▪ Make services available at central location to reduce travel time and costs of clients ▪ Improve utilization of services in remote areas
17. Insurance Schemes	▪ Focus on poor and disadvantaged ▪ Provide services at affordable costs ▪ Long-term solution to health problems ▪ Improved choice of health units ▪ Reduce debt among poor due to health costs

Services

The services can be categorized as:

Type I: Basic Primary Health Care Services

1. Maternal health

- Gynecological healthcare services (institutional and outreach)
- ANC services
  - Minimum 3 ANC check-ups
  - Prophylaxis of iron and folic acid for at least 3 months
  - Tetanus toxoid immunization
  - Detection of danger signs of pregnancy
  - Counseling and services for institutional delivery
- Inpatient services
  - Normal delivery
  - Elective LSCS
  - Minor surgeries

2. Child health

- Pediatric healthcare services (institutional and outreach)
- IMNCI for children
  - Management of Acute Respiratory Illnesses
  - Management of Diarrhea and Dehydration
  - Management of malnutrition and growth monitoring of under fives
- Immunization

3. Family planning / Reproductive health services

- Clinical FP services (Cu-T/ Injectables/Sterilizations)
- Clinical services
- Syndromic and clinical RTI/STI management
- Counseling services on
  - Adolescent health issues
  - Breast feeding
  - Natural family planning methods like lactational amenorrhea method (LAM), safe period, etc.
  - Modern Family Planning methods like condom and oral pills
- Medical termination of pregnancy (MTP)
- MVA

4. Pharmacy services

5. Lab services

- Hemoglobin estimation
- PCV and ESR

- Peripheral smear for anemia
- Peripheral smear for malaria
- Urine examination (for sugar and proteins)
- Diagnostic services for RTI/STI management

6. Emergency management and transportation

Type II: Emergency Obstetric care, 24-hour services and specialist care
The specialist services available in this package will include:

- All the above services and
- Emergency LSCS
- Specialist healthcare services –
  - Pediatrics
  - General surgery
  - Orthopedics
  - Gynecology & obstetrics
  - Skin and STD
  - Anesthesia
- Intensive Care Unit for adults and children

3.2.4 Issues requiring attention for implementation of PPPs

PPP is a new initiative and its success or failure depends on several critical issues. Several systemic changes need to be brought about to ensure that PPP is successful, sustainable, and equitable. These changes can be classified as:

- Capacity building
- Advocacy
- Accreditation
- Regulation

1. Capacity building

To ensure that the PPP interventions are successful, the entire process has to be streamlined with procedural transparency and replicability. Capacity building has to be undertaken for both the public and private partners to ensure optimal performance in their respective fields.

The private sector capacities have to be developed in delivering the RCH services without compromising on quality standards. It has to be sensitized towards its social role and responsibility in universalization of RCH services. The private sector is also varied in terms of the agency (NGO / Corporate etc.) and the type of partnership (donation of land, contracting out of service, social franchising etc.) in PPP, and depending on its type, there is a need to orient the private partners for effective planning, management and delivery of RCH services.

At the same time, there is an inherent need to develop the competencies of the public health sector at the national, state and eventually the district levels. For the success of PPP, it is important to ensure that at the national level the public sector has the wherewithal for conceptualizing, planning and operationalizing this

partnership, the state level has the competency of monitoring and learning about the processes and at the same time develop the capabilities of the district management units.

A. Program management skills

Program management skills will have to be enhanced at different levels of the government - the center, the states and the districts - for the effective management of the program. The following skills will be enhanced in the program:

- Assessments of the local needs to determine RCH services required (determine the service package/ basic benefit package) and thereby determine the process of selection of service providers.
- Training of the PPP personnel in program management skills like NGO management, use of SIFPSA NGO selection model, joint appraisal for the chosen franchisers and franchisees skills for review of financial performance of NGOs, etc. will be required.
- There have to be functional systems for:
  - Management of logistics
  - Procurement of goods
  - HR needs
  - Public relations
  - Service monitoring

B. Technical skills

One of the primary aims of PPP is to ensure availability of good quality services at affordable prices. This will include maintaining standards of care; hiring experts for providing specialist services and ensuring their regular availability. This entails improving the technical efficiency of the system.

To ensure that technical efficiency is enhanced and sustained, the technical resources available will have to upgraded and updated through CMEs (Continuing Medical Education) and CPEs (Continuing Professional Education) for the staff of the state RCH-PPP Cell and the franchiser. This will also mean creating new and attractive service packages or franchised clinics, which are approached by the people. The existing franchisees will have to be networked and mapped. It should be ensured that they stay in the network and at the same time provide quality services. Market competition from other contenders will be utilized to ensure high quality and cost-effectiveness.

C. Problem solving skills

The success of the PPP venture is dependent on the spontaneity of action of the human resources employed. The workforce, from the field workers to the clinic staff, has to be responsive to the local needs. This requires developing their capacities for quick decision-making, evidence-based management and optimum utilization of resources within the franchisee network. There is an urgent need to think “out-of-the-box” and develop innovative solutions for local problems to ensure the success of PPP. This will therefore require training and capacity building at different levels to increase efficiency and deliver the best service.

D. Financial systems management

Since PPP involves interface between the public/government and many private stakeholders, laying accountable and transparent financial systems is critical for its success. This will include setting guidelines for fund management, disbursement, utilization, developing new software packages for finance management or even adopting pre-existing packages for efficient financial management information systems (FMIS)

etc. It would thus have to be ensured that either the functionaries involved at critical financial management positions are professionally qualified to do so, or should be trained to be able to perform the function optimally.

2. Advocacy

A. Advocacy aimed at stakeholders for creating a positive environment

Since PPP is a novel approach towards ensuring access of the public to good quality services at affordable prices, perceptions about the initiative can "make or break" the program. There is a need for extensive advocacy, aimed at the stakeholders involved, to ensure that they understand and can relate to the program goals and objectives. Identifying the stakeholders (employees, unions, doctors, nurses etc.), keeping them informed of the changes proposed, the new structure and giving them opportunities and incentives to perform within the changed settings are critical initiatives, necessary for success. This will also lead to extensive stakeholder consultation, active involvement of stakeholders and thus a very responsive system.

B. Advocacy for scaling up the initiative of PPP

Small-scale models catering to specific local needs of one or few districts have been working in many different parts of the country. However, in the PPP initiative, there is an urgent need to have the foresight to decide about the course of action, in order to be able to scale-up the process within the dynamic health system. On-going documentation and analysis of successes and failures will be required to attract the appropriate agencies for scaling up the initiative from a few PPP units to many.

C. Advocacy for successful PPP models in action

Once a model works, it is important to understand the critical phases it passed through and what made it work. It is essential to disseminate the knowledge regarding the successful strategies employed (e.g. employee relocation, employee support, local people's participation etc.) and to ensure that these are acknowledged, supported and appropriately replicated by all stakeholders.

D. Advocacy for the benefits of PPP to the poor and inaccessible areas

For the government, the purpose of encouraging PPP is to ensure access and greater penetration of good quality services even in difficult and hard to reach areas. There has to be intensive advocacy so that the people understand the larger social gain from partnerships between the public and the private sector. The private sector has view profit as a by-product of a responsibility the private sector takes on in partnership with the public sector for improving access to services. Thus despite the fact that private-sector provider does derive some financial gains out of the venture, this should be viewed as contributing positively to social responsibility.

E. Demand-generation through advocacy

For the PPP and franchise initiative to succeed, special drives/ strategies will have to be followed to attract people to the quality clinics. The strategies have to be innovative and user-friendly to attract even illiterate and uninformed clients. Moreover, the feedback received from the people will be critical for the continuation of the program. Thus it becomes imperative that the people are aware of the quality of services they should receive at these clinics. The "branded" clinics and health facilities should be advertised so as to create demand for such services and thereby achieve the *economies of scale*, to make the PPP efforts sustainable.

3. Accreditation

Since PPP also involves the outsourcing of care (whether primary or specialized clinical, laboratory and other services) in a big way, there has to be an efficient and evidence-based quality monitoring mechanism. This will include:

- **Laying down protocols for quality assurance**

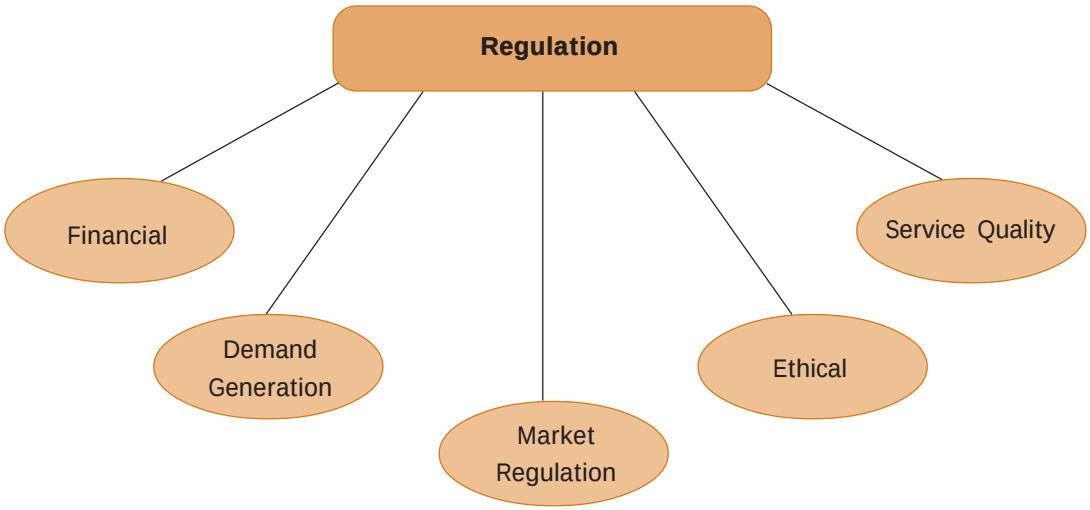
  Clinical guidelines for RCH care, counseling, general examination, FP services, counseling, financial record keeping, laboratory services, etc., will be put in place by the government by consulting various professional organizations like FOGSI, IMA, IAP IAPSM and NIHFW, to ensure that the clinical services are appropriate, user-friendly and evidence-based. The guidelines would be treated as the minimum standards of quality. This will reduce unnecessary expenditure on investigations etc. and will also avoid poor quality of services.

  The government would aid the professional medical associations like IMA and strengthen them to design and operationalize "Gold Standards" for quality of service delivery.

  The Council of India (QCI), with its headquarters in Delhi, will be approached and the agencies listed by it will be used for accrediting the PPP clinics and partners in service delivery. The list of certified agencies provided by QCI would be provided to the states to approach and further refine and tailor the standards for health care.

- **Bureau veritas/ ISO certification** from service quality accreditation agencies like QCI, working in the non-health service sector can be obtained to ensure quality.
- A monitoring agency will be set up to ensure that protocols are followed by franchisees by conducting routine and surprise checks on the franchisees in different parts of the state. The mechanisms followed will include client satisfaction surveys, mystery client surveys, FGDs with a sample of users and franchisees and compilation of "service-quality data" with the help of checklists.
- **Branding** of healthcare institutions as "government certified" etc. and with a specific brand name would help create a ready market of clients willing to "go an extra mile" to avail services from such providers.

4. Regulation



- **Financial regulation**

  This will involve following procedures laid down to control and monitor the flow of funds. There is a need for transparent record keeping because the initiatives involve exchange of funds between the government and private providers and credibility of the transactions needs to be ensured. Transparency of financial dealing will act as a big advocacy tool for the projects and will also ensure better fund utilization. Fund disbursement would be done on the basis of the quality of services provided and the performance levels achieved.

- **Service quality monitoring and regulation**

  The service quality of the clinical, laboratory and diagnostic services in addition to the housekeeping and pharmacy services are critical for the success of the initiative. The economies of scale will help cut cost, but it needs to be ensured that this does not happen at the cost of quality. The guidelines set for delivery of services will be adhered to diligently.

- **Ethical regulation**

  Since private providers are involved, maximizing resource gains would invariably be the aim of the private partner, it is essential to strictly follow the ethical guidelines for clinical examination, treatment initiation and continuation, resource allocation and financial disbursement. Ethical cells would be set up in all the professional bodies. They will act as the regulatory agents of professional ethics and prepare ethical guidelines. These guidelines will have to be strictly adhered to in order to earn the goodwill of the people and ensure success of the initiative.

- **Market-based regulation**

  Since two or more franchising/ contracting agencies will be involved in the same region, they will act as competitors in providing RCH services. Thus there would be an automatic feedback operating at the local level, ensuring optimum quality of services.

  Success stories from one experience will find their way into the others and innovations are bound to abound in the competitive environment. The state PPP cell and NHSRC will be required to document and analyze the experience and share them with the partners on a regular basis to allow replication of successful strategies.

Role of center and states

Center

The center will design and direct the PPP initiative in different states, which means discussing the PPP options available , helping them choose the “right mix” based on state-specific requirements and capacity building of state PPP units at the state level (through transfer of systems and know how, etc.). The center will initiate and operate the PPP venture through the NHSRC-PPP and SM unit.

- *Developing standards and mechanisms for quality control of public and private providers*

  Technical divisions of the MoH&FW, GoI in consultation with FOGSI, IMA, IAP and other professional bodies would formulate guidelines/ protocols and document the appropriate ways of providing healthcare. This would include clinical, laboratory and diagnostic services for health, housekeeping, waste management and other related issues. Only the facilities conforming to the set standards would be able to participate in the initiative. These guidelines will be constantly revised and efforts will be made to ensure that health professionals are aware of these during the course of their professional training.

- *Developing capabilities of professional associations like IMA*

  One of the lessons learnt from the RCH Phase I project has been the need to develop service-quality standards. Since the professional organizations like IMA, FOGSI, IAP and Nursing Council of India have been involved in delivery of clinical care in both the private and the public sectors, it is natural that they should be involved in developing these standards. However, there is first a need to understand their present structure, mode of functioning, operations and procedures, etc. and develop mechanisms for institutionalizing this arrangement with the government and the franchisee. This is also important for the training and capacity building of members of associations that provide health care all across the country. Moreover since the guidelines will be developed by these associations in consultation with the members, there will be a greater possibility of adherence to them.

- *Launch social franchising models in EAG states (UP/ MP/ Bihar/ Jharkhand/ Chattisgarh / Uttaranchal/ Jammu and Kashmir)*

  Since social franchising is a new initiative, there is a need for the center to play a leading role in its implementation. As a result, social franchising will be operationalized in phases, covering five EAG states (Bihar / Jharkhand/ Madhya Pradesh / Chattisgarh/ Uttar Pradesh) in the first phase.

- *Build technical capacities for PPP implementation at the center and states; respond to requests for the technical assistance from states*

  The conceptualization, planning and implementation of social franchising in the initial five states will require a strong central technical base. This will be developed at the center to implement and monitor the progress of social franchising and PPP schemes. The center will also undertake capacity building of the state management units for monitoring implementation of PPP mechanisms. Center will also attend to the requests for technical assistance from the states on various aspects such as preparing contracts, training on clinical standards, management systems and financial management HMIS etc.

  The PPP initiative requires very clear and specific indicators for monitoring outputs. The GoI will develop the systems and build the capacity of the state units to implement the monitoring systems effectively. GoI will provide guidelines for standard protocols to be followed, accreditation and monitoring reports.

- *Provide budget heads and mechanisms for fund flow, including e-banking*

  PPP is a partnership of multiple stakeholders and the efficient performance of each is critical for its success. The funds for financing PPP will be taken from earmarked budget heads of the center and the mechanisms for reimbursements and payment to states and finally the franchisees will need to be developed.

  There will be an urgent need to develop financial and accounting systems, procedures for quick verification of claims of franchisees and procedures for reimbursement of expenses to the franchise organizations. To ensure efficient and responsive systems there will be a need to settle claims for reimbursements fast and later verify their authenticity.

  The government is willing to undertake several innovative new fund flow mechanisms like e-banking which ensure the transfer of monthly claims to the account of the franchisee organization and thus decrease the pressure on its limited resources. Any miscalculations in the claim will be verified while cross-checking the claim and subtracted from the next payment plan.

- *Stakeholder dialogue for policy development*

  Since PPP is a novel concept and only limited experiences are available through small-scale initiatives in select locations, its expansion on a large scale requires careful analysis and strategic planning. The government will initiate steps to facilitate development of different PPP mechanisms. It will also ensure continuous dialogue and discussions with different public and private partners to develop the policy.

  Various groups representing the community, private stakeholders, public sector, employees and donor agencies in the RCH program will be consulted to develop a comprehensive and holistic approach to PPP.

  The PPP initiative will have special focus on developing strategies to target the under-served areas and disadvantaged social groups in different parts of the country. Equitable distribution of health services and universal access for all will be the main objectives of the PPP mechanisms.

- *Creating a user-friendly website for developing policy, strategies, operational plans and disseminating information on successes in PPP*

  The PPP initiative will have a separate section on the website of the MoH&FW. The aim of this user-friendly website will be to disseminate information, guidelines, plans and procedures followed in implementing PPP. It will ensure transparency and also help to receive quick feedback from different partners and beneficiaries on the initiatives undertaken. The partnerships that are successful in the field will be highlighted and the processes leading to their success will be analyzed for replication elsewhere. Private partners will be encouraged to develop better strategic plans for vulnerable areas.

- *Document and disseminate models of PPP (operational examples)*

  The PPP models that are successful need to be replicated appropriately. The success stories will be documented, analyzed and disseminated and strategies to rapidly scale up successful interventions will be prepared.

States

Following the guidelines of Government of India, the states will select units for different PPP mechanisms in keeping with their requirements. The states will then enter into agreement with different agencies to execute the selected PPPs and build their capacities. The "implementation" task would also involve micromanagement of the program and ensuring that basic objectives are met and specific, locally relevant activities are initiated.

- *Interim accreditation*

  Since PPP is a relatively new initiative the center has taken a lead role and has plans of developing service delivery standards with the help of professional associations. However, in the interim period when the PPP is being implemented, the state governments will be entrusted the task of certifying and accrediting the service delivery units for the PPP initiative. The center is contemplating development of "*Indian Primary Health Care Standards*" that are applicable to all primary health care units in the country.

- *Improvement in government's capacities to monitor and regulate the private sector*

  The magnitude and form of partnership with the private sector will vary from state to state. In addition to the center that will be overseeing the functioning of the PPP mechanisms, monitoring of the PPP units at the local (state) level would be done by the states.

  The PPP units at the state level will be responsible for the day-to-day monitoring of the quality of services and access and availability of these services according to the plans. This will involve regulation

and monitoring of the private sector to provide the basic minimum package of services, avoid unnecessary expenditure on irrelevant investigations, overcharging and other unethical practices, etc. Capacities of PPP units will be improved to effectively monitor and regulate PPP mechanisms.

PPP units will be monitored at regular intervals and the state PPP cell will provide feedback to the central PPP unit and contractors implementing PPP mechanisms. The state PPP cell would also ensure that the PPP mechanisms follow standard protocols, ethical procedures, etc.

- *Capacity building of district units*

  The state PPP cells would also work towards capacity building at the district level for monitoring, evaluation and support of the day-to-day activities of the initiative. All members of district management units will be trained in management of PPP mechanisms, monitoring of activities and preparation of reports to be submitted at periodic intervals.

3.3 NGO Participation

3.3.1 Introduction

Partnership with NGOs has been listed as one of the strategic themes by the NPP 2000. The Action Plan mentions the objectives of the collaboration. The work of NGOs is essentially supplementary and complementary to that of the government. NGOs have a comparative advantage of flexibility in procedures and rapport with the local population. The GoI therefore proposes to involve NGOs in using strategies for expanding access to health services.

The DoH&FW envisages collaboration with NGOs through state governments. The Mother NGO (MNGO) Scheme and the Service NGO Scheme are expected to facilitate this process. Both the schemes focus on partnerships between the government and NGOs for improving RCH service delivery. Indicative service delivery guidelines for the different RCH components are outlined.

In the Ninth Five Year Plan (1997-2002), the DoH&FW introduced MNGO Scheme under the RCH program. Under this scheme, the DoH&FW identified and sanctioned grants to selected MNGOs in allocated district/ s. These MNGOs, in turn, issued grants to smaller NGOs, called Field NGOs (FNGOs). The grants were to be used for promoting the goals/ objectives as outlined in the RCH program of GoI.

The underlying philosophy of the scheme has been one of nurturing and capacity building. Broadly the objectives of the program are:

- Addressing the gaps in information or RCH services in the project area
- Building strong institutional capacity at the state, district/ field level
- Advocacy, awareness generation

In keeping with the philosophy of capacity building, four NGOs had been identified as Regional Resource Centers (RRC) to provide technical support to the MNGOs.

The lessons learned over the past three years have indicated that modifications need to be made in scheme. These are in terms of decentralization, simplification of fund disbursal process, rationalization of jurisdiction, and interface with local government bodies. Additionally, it was found that involving the NGOs in service delivery and addressing gender issues cross cutting the RCH service areas would be required to

make the program more effective.

3.3.2 Scheme components

In addition to capacity building and nurturing small NGOs, the scheme focuses on addressing the unmet RCH needs. This is possible by involving NGOs in delivery of RCH services in areas which are **underserved or unserved** by the government infrastructure. Accordingly, NGOs are expected to move from mere awareness to actual delivery of RCH services.

Unserved and underserved areas are those socio-economic backward areas which do not have access to health care services provided by the existing government health infrastructure, especially urban slums, tribal, hill and desert areas including SC/ ST habitations.

These areas include regions where the post of medical officer (MO), ANM and LHV have been vacant for more than 1 year, the PHC is not equipped with minimal infrastructure, or it has poor performance on critical RCH indicators.

Additionally, interventions are expected to address gender issues. Proposed interventions must seek to enhance male involvement and partnership in improving the reproductive health status of women and children. The interventions must also include adolescent population. Community needs to be adequately mobilized to generate demand for RCH services.

Greater emphasis on service delivery means that the service providers are able to measure outcomes concretely. Hence, the role of MNGO becomes one of an active facilitator and manager of the project and not only a fund distributor.

A decentralized approach is adopted in the management of the MNGO Scheme. This means that the state RCH society will implement the scheme. The MNGOs are members of the District RCH Society.

The role of GoI is one of policy guidance, funding and technical support.

In order to optimize results, the NGO is expected to complement and supplement the government health infrastructure and not substitute it. The NGO is expected to develop more effective linkages with local governments and government departments, and establish networks with technical and resource institutions.

Rationalization of jurisdiction is done to enable the NGOs to provide in-depth service in the project areas and optimize resources. The project duration of three years is extendable to five years, which facilitates long-term planning and stable implementation.

3.3.3 Role of MNGOs and FNGOs

FNGOs under the MNGO Scheme are involved in service delivery in addition to advocacy and awareness generation. The key service delivery areas under the MNGO Scheme are:

- Maternal and Child Health
- Family Planning
- Adolescent Reproductive Health
- Prevention and Management of RTI

- Some MNGOs have expertise in various aspects of development but limited expertise in the health sector. In order to provide hands-on experience in implementing RCH service delivery interventions to MNGOs, the scheme provides them with funds for the implementation of demonstrative service delivery projects in the allotted areas. The scope and scale of the project can be compared to that of the FNGO project.

- To facilitate implementation of service delivery projects by FNGOs, the MNGOs must have a dedicated team of staff including a Project Director with project management experience, preferably with regard to health/ RCH, and a qualified trainer.
- The MNGO cannot simultaneously apply as a Service NGO (SNGO) since these are two distinct functions.

The role of MNGO includes the following functions:

- Identification of unserved and underserved areas
- Release of advertisements for FNGOs and their identification and selection
- Motivating NGOs, CBOs, SHGs and other local level bodies in case of non-availability of suitable FNGOs
- Development of base-line data through CNA and end-line project data
- Impart project orientation to FNGOs
- Development of proposals including output and process indicators for approval
- Providing IEC materials to FNGOs
- Capacity building of FNGOs
- Imparting technical support to FNGOs for induction and in-service training of project staff
- Ensuring that qualified staff is appointed by FNGO according to the job requirement and support their search for the same through development of TOR, information on resources
- Including groups like DWACRA, Mahila Samakhya, NYK, SWA Shakti in the FNGO orientation and frequent interaction
- Liaising, networking and coordinating with state and district health services and Panchayati Raj Institutions, linkages with other NGOs and technical institutions
- Monitoring performance of FNGOs and progress of the project through supportive supervision
- Exchanging and sharing learnings and experiences with other MNGOs in the state and region
- Working closely with RRCs and state NGO coordinators
- Documenting best practices
- Submitting quarterly financial and project progress reports to state RCH Society and District RCH Society
- Submitting statement of expenditure and utilization certificates as per Memorandum of Understanding (MoU)

The role of FNGOs includes the following functions:

- Conducting community needs assessment
- Developing proposal based on baseline data
- Providing RCH services as proposed
- Working towards convergence with ICDS, rural development and Anganwadi initiatives.
- Orienting members of the PRI , Mahila Samakhya, NYK, SWA Shakti, DWACRA and Mahila Swasthya groups, with the RCH program
- Sharing information on the type of services that can be availed from the government health infrastructure

- Creating conducive working environment for the ANM
- Facilitating the monthly RCH camps conducted by the PHC through mobilization of community
- Timely submission of quarterly progress reports, utilization certificates, etc. as per agreement with the MNGO
- Documenting and maintaining records and registers

3.3.4 Institutional framework

3.3.4.1 Government of India

Government of India provides support through policy guidelines and release of funds to state RCH Society.

3.3.4.2 Regional Resource Centers (RRCs)

Technical support for MNGO capacity enhancement, documentation of best practices, induction and in-service training, liaison with the state government, updating database on RCH issues and development of MIS is provided by RRCs and other technical institutions whenever necessary. This is expected to complement the technical support decisions made by the state RCH Society.

Apex Resource Cell (ARC): Located within the NGO division, the ARC will coordinate the activities of all the RRCs, manage budgets, and facilitate RRC coordination and interaction with state governments.

Regional Director (RD)

- Receive all applications from MNGO applicants and conduct pre-scrutiny/ desk review of all applications, based on a checklist
- Provide collated information on the NGO applications to the state RCH Society and convene meetings of the State NGO Committee until the State NGO Coordinator is identified and appointed
- Participate in the review of applications as a member of the state RCH Society.
- Undertake field visits if required and submit tour reports to state Secretary (FW) and Assistant Commissioner (NGO) GoI.

State RCH / FW society

The state RCH/FW Society comprises of a technical NGO Committee called the state NGO Committee and ensures the placement of state NGO Coordinator. The responsibility of the State RCH Society includes selection of MNGOs, fund disbursement, capacity building, training, monitoring and evaluation.

State NGO committee

The state NGO coordinator convenes the meeting of the state NGO committee, chaired by the Secretary (FW) or his nominee. Until the state NGO coordinator is identified and appointed, the Regional Director convenes the NGO committee meetings. The presence of GoI representative, RD and state NGO Coordinator is mandatory. The RRC and Director (FW) are also members of the Committee.

For review of NGO applications:

- On receiving the pre-scrutiny/ desk review reports from the RD's office, the state NGO Committee convenes a meeting to review NGO applications and prepare the agenda.

- The Secretary (FW) and other members of the committee are invited to attend the meeting.
- Minutes and decisions taken are recorded and communicated to the GoI and respective NGOs

The primary responsibilities of the state NGO Committee are:

- Selecting MNGOs
- Releasing grants–in–aid as per agreement
- Monitoring of MNGOs
- Organizing meetings to review the MNGO performance from time to time and ensuring timely release of funds
- Commissioning MNGO evaluation through external evaluating agency
- Sending utilization certificates to GoI
- Acting as arbitrator in case of dispute

State NGO coordinator

- The full time NGO Coordinator is responsible for the management of DoH&FW-supported NGO schemes, including the MNGO Scheme.
- The roles and responsibilities of the NGO coordinator are one of liaising, coordinating and supporting the MNGOs.

District RCH society

The District RCH Society constitutes a technical committee called District NGO Committee for selection and approval of FNGOs and MNGO projects.

Functions:

- Selecting and approving FNGO projects.
- Approving and sanctioning the MNGO project proposal based on FNGO projects.
- Facilitating the signing of MoU between the MNGO and the District RCH Society.
- Sending the signed MoUs to state RCH Society for release of funds and informing GoI.
- Holding review meetings to assess performance of FNGOs and MNGO.

Inter-Departmental linkages

NGOs under the MNGO scheme are expected to network with PRIs, women's groups including self-help groups, youth networks, teachers, parents and other members in the community.

3.3.5 Service NGO scheme

Introduction

NGOs with an established institutional base and delivery infrastructure are encouraged to complement the public health system in achieving the goals of the RCH program. Any NGO that is engaged in directly providing integrated services in an area co-terminus to that of a CHC/ block PHC with a population of 100,000 (approximately 100 villages or more) is called a Service NGO (SNGO). These SNGOs are expected

to provide a range of clinical services directly to the community, for example, services for safe deliveries, neo-natal care, treatment of diarrhea and ARI, abortion and IUD services, RTI/ STI etc. These services must reach out to male and female population in all age groups. In order to provide these services effectively, the applicant NGO must have appropriate staff, infrastructure such as clinic/ hospital, ambulance, etc.

The Service NGO Scheme is expected to help achieve the RCH objectives in areas which are unserved or under served by the public health services and infrastructure, and complement the MNGO Scheme. SNGOs differ from MNGOs in terms of their scope and coverage of work. SNGOs can provide a range of clinical and non-clinical services directly to the community, while the MNGOs provide the same through the FNGOs. While FNGOs can take up a particular service delivery area, SNGOs are expected to provide integrated RCH services. The SNGO may be provided with a non-recurring one-time grant for infrastructure improvement as required, but FNGOs are not eligible for the same.

SNGOs provide the comprehensive range of clinical and non-clinical services in the following RCH areas:

SNGOs implement large-scale projects in the key RCH service areas covered under the MNGO Scheme viz. family planning (such as setting up of IUD clinics), Adolescent Reproductive Health, Maternal and Child Health, and RTI. Additionally, SNGOs can take up other areas such as MTP services and 'Dai' training. SNGO proposals for service delivery in emerging RCH areas such as gender-based violence and male participation will be encouraged. Gender and community mobilization processes are expected to be cross cutting in all aspects of service delivery. Community needs to be adequately mobilized to generate demand for RCH services.

The institutional framework for the FNGO Scheme is similar to that of the MNGO/SNGO schemes.

The GoI has framed guidelines for involvement of NGOs under various schemes to facilitate the state governments.

3.4 Infrastructure Strengthening

3.4.1 Facility surveys

The existing infrastructure in the selected functional PHCs, FRUs/CHCs in 21 districts across the country was surveyed under the RCH Phase I in 1999 for their present status and effectiveness and findings have been summarized in the facility survey report prepared in 2001 by the MoH&FW. These findings have now been reviewed and discussed in the light of 'ensuring total safe motherhood and new born care'. It is strongly felt that the infrastructure needs upgradation by strengthening some of the existing facilities and also by introducing new facilities to make these health centers meet the need of the hour. Another facility survey currently being conducted will throw more light on the issue

3.4.2 Results of facility survey

The findings of the facility survey (1999) about the key facilities in place, conducted in 760 FRUs & 866 CHCs (total no. of FRUs / CHCs – 3,077) and 7,959 of 22,928 PHCs have been summarized in the Table 3.1.

Table 3.1 - Summary of Findings of the Facility Survey 1999

S. No.	Facility	Availability In FRU	Availability In CHC	Availability In PHC
1.	Own buildings	98%	96%	92%
2.	O T	93%	86%	——
3.	Labor room	36%	28%	28%
4.	Overhead water storage tank & pump	82%	71%	——*
5.	Blood bank / BSF / Linkage with DBB	17%	9%	——
6.	Diesel Generator	71%	52%	——
7.	Telephone	80%	62%	20%
8.	Computers	2%	2%	——
9.	Functional vehicle	73%	61%	29%

* 62% of the PHCs surveyed have water supply facility but no storage tanks or pumps, etc.

Note: Data available from the Facility Survey done in 1997 is being used in this document. However, all states have been asked to conduct a situational analysis and resource mapping while designing their state plans.

3.4.3 Extension of existing facilities

After deliberations, it is proposed that all of these essential facilities be to be introduced in a phased manner in the remaining centers under RCH Phase II, prioritizing the states classified as EAG and the states in the North-east.

3.4.3.1 New construction (Annexure C)

It is proposed that 8,092 new sub-centers be constructed in the EAG and North-eastern states in a phased manner during RCH Phase II. Details are given in the norms section on page 243. No new construction of buildings for new FRUs, CHCs and PHCs, even in the EAG states, is proposed in RCH Phase II.

The proposed new sub-center shall cover an area of approximately 73.5-sq.m including the ANM residential quarters. It would be a RCC framed structure with ordinary internal and external finishes.

The unit cost, as estimated in March 2003, for constructing sub-centers including normal internal and external finishes, electrical conduits and wiring, plumbing and sanitary works, etc. based on the CPWD plinth area rates (1992) amounts to Rs. 5.13 lakh (excluding the cost of land) at the rate of Rs. 7,000 per sq.m. of construction. However it may be noted that the unit cost of construction, especially in the North-east may vary depending up on the location, availability of construction material, method of construction, etc. Further, the rates do not include the natural escalation which needs to be added for the lapsed period at the rate of 5% per year at the time of construction.

3.4.3.2 Operation Theatres (OT) (Annexure C)

Operation theatres are essentially required for managing high-risk deliveries and for emergency obstetric care and at present OTs are available in only 90 % of the CHCs/ FRUs (refer Table 3.1). It is proposed that at least one OT should be provided in the remaining 10 % of the 1,423 FRUs/ CHCs.

The proposed OT would cover an area of approximately 27 sq.m. with ordinary finishes, and shall have additional area of approximately 57 sq.m. meant for patient preparation, changing rooms for doctors, post-operative care, scrub area, store, disposal area, etc. Further it is proposed that OTs be air-conditioned as this would help in controlling the concentration of harmful bacteria, prevent infiltration of less clean air into the OT, create an air flow pattern that carries the contaminated air away from the OT. Air-conditioning further helps in maintaining a comfortable environment for the patient and operating team. For air-conditioning a 10 TR package type AC system with microbe filtration, booster fan, etc. can be installed.

The center specific OT layout can be finalized at the time of construction, in consultation with the center in-charge. Once these operation theatres are commissioned, they should be regularly monitored with respect to air flow/air circulation to prevent infection.

The estimated unit cost for setting up of above explained OT and service area, based on the CPWD plinth area rates (1992) works out to be Rs. 6 lakh (excluding cost of land) at the rate of Rs. 7,350/- per sq.m. for OT area and Rs. 7,000/- for non-OT service area. Similarly the estimated unit cost of providing AC as explained above is about Rs. 4 lakh. These rates do not include the natural escalation, which needs to be added at the rate of 5% per year at the time of construction. However it may be noted that the unit cost of construction, especially in the North-east may vary depending on the location, availability of construction material, method of construction, etc.

3.4.3.1 Labor room (Annexure C)

Labor rooms are required to ensure safe motherhood and also for providing round-the-clock delivery services. At present, labor rooms exist in 36% of the FRUs, 28% of the CHCs and 28% of the PHCs only. Under RCH Phase II it is proposed to set up labor rooms in the remaining 968 FRUs/ CHCs and 50% of the remaining 4,524 PHCs in EAG and North-eastern states.

The proposed labor room for FRU/ CHC would have an approximate area of 55.7 sq.m. with space for septic delivery room, aseptic delivery room, toilet, disposal, etc. Similarly, the labor room for the PHCs would be approx. 29 sq.m. in size with similar facilities. Once these labor rooms are commissioned, they should be regularly monitored for infection control.

The estimated unit cost for setting up a labor room for a FRU/ CHC and PHC based on the CPWD plinth area rates (1992) works out to be Rs. 4 lakh and Rs. 2.1 lakh respectively, excluding the cost of the land, at Rs.7, 000 per sq.m. The rates do not include the natural escalation which needs to be added at 5 % per year at the time of construction.

3.4.3.4 Overhead water storage tanks

For smooth functioning of OTs, labor rooms and other mother and child care services at the centers, it is very important to ensure uninterrupted water supply. Round-the-clock water supply can be ensured by installing overhead/ terrace water storage tanks (may be of readily available HDPE tanks) with sufficient capacity to store a day's supply of water, pumps for filling these tanks from the source, underground storage tank of same capacity (wherever required) and distribution piping network (may be of galvanized iron pipes or PVC pipes).

At present this uninterrupted water supply facility is available in 82% of FRUs and 71% of CHCs only. In RCH Phase II it is proposed to have this facility in the remaining 708 FRUs/ CHCs nationwide. Further it is recommended that the water should be tested periodically for its purity and safe usage and proper treatment should be given if necessary.

The estimated unit cost for such a facility in an FRU/ CHC works out to Rs. 2 lakh.

3.4.3.5 Linkage with district blood banks / blood storage facility

Having own blood storage facility and/or a linkage with the existing district blood bank is essential for the

health centers to ensure safe, proper and sufficient blood supply to meet the demand around the clock. At present, only 17% of all the FRUs and 9% of the CHCs have this linkage facility with the district blood banks. About 1,700 FRUs have also been provided with blood storage facility.

In RCH Phase II it is proposed to extend this facility to the remaining 1,238 FRUs and CHCs in the EAG states. Further, necessary measures would be taken to link these FRUs/ CHCs with respective district blood banks, a facility which can serve as a standby.

Blood storage facility can be created in the blood banks by installing refrigerators with line voltage corrector/ stabilizers and having capacity to store a minimum of 60 unwrapped 450ml bags of blood. An area of approximately 1.5m x 1m is required to install this refrigerator, which would run on 0.5 KVA power from a 15 amp socket. The temperature should be kept around 4 degrees C.

Apart from the refrigerator, other components like centrifuge, VDRL shaker, etc. are required for proper storage of blood bags. The estimated unit cost for supplying this refrigerator would be Rs. 0.80 lakh (Blood bank refrigerator – Rs. 0.65 lakh, centrifuge – Rs. 0.05 lakh, VDRL shaker – Rs. 0.04 lakh, other minor accessories – Rs. 0.06 lakh). The rates mentioned here are as of February 2003 and cost escalation would have to be taken into consideration at the time of installation.

Further it is proposed in RCH Phase II to install walk-in deep freezer/ cold rooms for storage of vaccine, drugs, etc. in all the existing district hospitals in a phased manner starting with the EAG states. This clause should be included in the MoU to be signed with states.

3.4.3.6 Diesel generator

Diesel generators (DG) are required for ensuring emergency power supply in case the normal supply fails. At present 71% of FRUs and 52% of CHCs have DG sets. To ensure constant mother and child care, and for conducting - deliveries round the clock, RCH Phase II proposes to install DG sets in the remaining 555 FRUs/ CHCs and 50% of the PHCs (6,283 in number) in EAG and NE states.

It is proposed to install a 10 KVA DG set in the FRUs/ CHCs to take care of emergency equipment and lighting load. Similarly a 5 KVA DG has been proposed for the PHCs. The estimated unit cost of providing a 10 KVA DG set for a FRU/ CHC along with necessary cabling, amounts to Rs.2 lakh and similarly, a 5 KVA DG set for a PHC costs Rs. 1 lakh at Rs. 20,000.00 per KVA. The rates mentioned here are as of February 2003 and cost escalation would have to be taken into account at the time of installation of the DG sets.

3.4.3.7 Telephone connections

It is very essential for the health centers to have telephone connections. These would be of great help to the patients and also improve the connectivity between service providers and administrators.

At present 80% of the FRUs, 62% of the CHCs and 20% of PHCs have telephone connections. Under RCH Phase II, it is proposed to extend this facility to include two connections per center in the remaining FRUs/ CHCs in the EAG and NE states.

The estimated unit cost of installing two connections each for the FRUs/ CHCs amounts to Rs.6,000.00 per center and Rs. 3,000.00 for every PHC.

3.4.3.8 Computerization

Computerization of the existing health centers is the most sought-after facility because of its numerous applications ranging from assessment and maintenance of supply needs, consumption records, stock balances, maintaining records of distribution of contraceptives, sale receipts, clinical cases referred by reproductive health professionals (RHPs), running effective management information system, etc.

At present only 2% of the FRUs and CHCs are provided with computer facility. Under RCH Phase II, it is proposed to computerize all the 1,243 FRUs/ CHCs in the EAG states. The estimated unit cost of providing

computer facility would amount to Rs. 0.70 lakh.

3.4.3.9 Vehicle / Ambulance

Vehicles are essential to ensure transport readiness for both mother and child, to shift emergency cases from house to center, center to center, and also for the mobility of service providers.

At present, 73% of the FRUs, 69% of the CHCs and 21% of the PHCs have vehicle facility. In view of the increasing demand, it is proposed in RCH Phase II to extend this facility by outsourcing it to private vehicle contractors on hourly/ daily basis as the case may be, in the rest of the FRUs/ CHCs in EAG states only.

The estimated cost of outsourcing vehicles for a FRU/ CHC over a period of five years will come to Rs. 3 lakh (assuming that the vehicles will be used 10 times a month at the rate of Rs. 500/- each time).

3.4.4 New facilities proposed under RCH Phase II

Further it is proposed that the following new facilities are also introduced nationwide under RCH Phase II in a phased manner at the existing FRUs/ CHCs/ PHCs/ sub-centers, as the case may be, giving priority to the EAG states.

3.4.4.1 Newborn care corner

Studies conducted to evaluate the facilities in place, particularly for newborn care and child health under RCH Phase I, revealed that these facilities are unimpressive and also have poor coverage. Newborn baby care i.e. total care for newly born child is completely absent . Even the care given to children suffering from diarrhea, ARI, etc. is found to be of poor quality at the sub-center level.

Similarly at the PHC/ CHC level, the existing facilities for proper care of in-born neonates, out patient care and pre-referral treatment of sick neonates and children below 5 years of age, etc. are very poor and have inadequate coverage. Similar is the case with FRUs, where the existing facilities for care of in-born and referred neonates are insufficient.

Apart from the above, it is found that the awareness and infrastructure available for feeding, immunization, vitamin A, prophylaxis, etc. too is insignificant and poor coverage.

In view of the above, keeping the importance of newborn care and child health in population stabilization, it is proposed in RCH Phase II to develop specific newborn care corners in all the 1,243 FRUs/ CHCs and 50% of 10,775 PHCs in the EAG states.

This newborn care corner (NBCC) shall preferably be an enclosed area of approx. 30 sq.m. at the FRUs/ CHCs and 15 sq.m. at the PHC, with partition walls/ curtains, facility for water and power supply, etc. This area should be developed within the existing hospital set up by making certain alterations/ modifications to the existing rooms/ areas. Such areas would be identified to ensure minimum damage/ disturbance to the existing set up. The estimated unit cost for developing a NBCC (for civil and related works only) at a FRU/ CHC would amount to Rs. 0.4 lakh and Rs. 0.20 lakh at a PHC.

3.4.4.2 Hospital generated waste management / infection control

Various studies have revealed that bio-medical waste generated from different units of the hospital/ health center can cause serious health hazards which could also extend beyond the campus of the hospital/ health center. The health hazards can affect both personnel providing support services to the hospital and medical establishment and people exposed to improperly treated bio-medical waste.

Operation theatres, laboratories, OPD, labor rooms, treatment rooms, wards, etc. are the common areas where infectious bio-medical waste is generated.

Keeping in view the urgent need for effective and safe waste management and infection control, it is proposed under RCH Phase II to introduce Hospital Waste Management System in the existing health

centers nationwide.

This waste management system would broadly comprise waste identification, collection in color-coded collection bags and collecting bins/ containers, transportation by trolleys and disposal as per the existing facilities like land filling, etc. Apart from the above, needle destroyers and autoclaves for sterilization of surgical instruments would also be provided at the FRUs/ CHCs.

To start with, it is proposed to introduce this system in all the 631 FRUs /CHCs and 3,786 PHCs in the non-EAG states nationwide excluding the NE and SHSDP states.

The estimated unit cost of introducing this system is about Rs. 5 lakh (collection bins and trolleys – Rs. 1 lakh, autoclave – Rs. 3 lakh, needle destroyer – Rs. 0.50 lakh, preparation of land fill – Rs. 0.50 lakh) for the FRU/ CHC. Similarly, estimated unit cost of introducing this system is about Rs. 1.5 lakh (collection bins and trolleys – Rs. 0.5 lakh, needle destroyer – Rs. 0.50 lakh, preparation of land fill – Rs. 0.50 lakh) for a PHC.

3.4.4.3 TV, VCD/CD Player

Under RCH Phase II it is proposed to install TV and VCD/ CD players at various health centers for mass communication. Compact disks (CDs) on reproductive and child health care would be produced and these messages would be disseminated through supplied electronic media equipment at these centers.

To start with, this new facility will be extended to all the existing 1,423 FRUs/ CHCs in the EAG and NE states. The estimated unit cost of TV and VCD/ CD players would amount to Rs. 0.25 lakh.

3.4.5 Actions proposed under RCH Phase II

After analyzing the status and degree of maintenance of existing facilities at various FRUs, CHCs, PHCs and SCs nationwide, the following action plan was proposed for implementation in RCH Phase II.

3.4.5.1. Maintenance of existing facilities

It is felt that some of the FRUs/ CHCs, PHCs and sub-centers need proper repairs and maintenance for making them more suitable for providing quality services.

The estimated unit cost for this repair and maintenance work (which includes repair of plaster, flooring, doors and windows wherever required, painting, replacing minor fittings and fixtures, etc.) for a period of 5 years works out to Rs. 10 lakh for a FRU/ CHC, Rs. 5 lakh for a PHC and Rs. 0.5 lakh for a sub-center.

It is proposed to include this repair and maintenance of the existing centers, in the MoU to be signed with the states.

3.4.5.2 Upgradation and renovation of staff quarters

In RCH Phase II, it is proposed to renovate and upgrade the existing staff quarters (especially nurses residence and doctors residence at the centers where 24-hour delivery facility is available) nationwide with a total estimated cost of Rs. 2,500 lakh in a phased manner prioritizing the EAG states. Further it is proposed to include this upgradation and renovation of the existing staff quarters, in the MoU to be signed with the states.

The following norms are proposed for strengthening of infrastructure:

EAG & North eastern states:

- **New building construction** – Only sub-centers (including ANM quarters) in EAG & NE states. Approx. area is 73.5 sq.m (unit rate Rs. 7,000/Sqm)

- **Operation Theaters** – In the balance 10% FRU/CHCs in the EAG & NE states only 27 sq.m area & 57 sq.m area for preparation, doctor changing unit respectively, etc. (unit rate –Rs. 7,350/sq.m for OT & Rs. 7000/sqm for non-OT)
- **Labor room** – In the balance 68% of FRU/CHCs in the EAG & NE states and also in the balance PHCs (50% with 24 hour delivery facility) in EAG & NE states. 55.7 sq.m area for FRU/CHC & 29 sq.m area for PHC (unit rate – Rs. 7000/sq.m)
- **Uninterrupted water supply** – In the Balance 23% of the FRU/CHCs nationwide.
- **Blood storage facility** – In the balance 87% of the FRU/CHCs in EAG & NE states only.
- **Generators**- In the balance 39% of the FRU/CHCs in the EAG & NE states and 50% of the PHCs in the EAG & NE states only.
- **Telephone connections** – In the balance 29% of the FRU/CHCs in EAG & NE states only; 2 lines for FRU/CHC.
- **Computers** – Only for FRU/CHCs in EAG states.
- **Vehicle / Ambulance** – Outsourced only in the balance FRU in EAG states.
- **Newborn care corner** – In all the FRU/CHCs & 50% of PHCs in EAG states only.
- **TV, VCD / CD playe**r – Only for CHC/FRUs in EAG & NE states

Non-EAG states:

- **Operation Theater** – Balance 10% FRU/CHC nationwide
- **Labor room** – Balance 68% FRU/CHC nationwide and also balance PHCs nationwide (50% PHCs with 24 hour delivery facility)
- **Blood storage facility** – Balance 87% of the FRU/CHC nationwide
- **Generators** – Balance 39% of the FRU/CHC nationwide
- **Telephones** – Balance FRU/CHCs and PHCs nationwide
- **Computers –** Balance FRU/CHC nationwide
- **Newborn care corner** – FRU/CHCs
- **Hospital waste management system –** In non-EAG states nationwide, excluding NE & SHSDP states

3.5 Procurement

3.5.1 Introduction

The proper management of equipment and supplies is essential to the efficiency and effectiveness of RCH clinical and support services. Quality care depends upon the availability of appropriate equipment, materials and services. To ensure efficiency, and to reap benefits of scale, a supplies strategy is needed to:

- Address supply management arrangements to decide appropriate levels of purchasing activities at state, district and local level.
- Establish a modern, integrated, cost-effective logistics and supply chain for states.
- Set key performance measures and indicators.

In designing an RCH Phase II supply strategy the following areas need to be addressed:

- The scope of the strategy :

- What is handled in-house or outsourced?
- Non-pay expenditure on items such as pathology, IT, drugs
- Non-pay expenditure on services such as outsourced contract management
- Information needs and reporting levels
- Physical distribution and storage
- Payment systems

- The need for the supply strategy to integrate with other activities such as environmental, human resources and health and safety arrangements
- The ways in which the strategy will support other objectives such as estates management and cost improvement programs
- Decision-making delegations with respect to outsourcing, acquisition, procurement, tendering, contracting and expenditure limits
- The level and balance of collaboration nationwide, state-wide and locally.
- Expectations of staff and suppliers' behavior in terms of public accountability and adherence to statutory and mandatory regulations (e.g. standing orders, financial instructions and procurement regulations).
- Policy or intentions for e-commerce

3.5.2 Procurement in RCH Phase II

In the initial two years of RCH Phase II the MoH&FW will be responsible for procurement of drugs, vaccines, equipment, kits and contraceptives as done in RCH Phase I. Procurement plans for year 1 and year 2 have been shared with the development partners. The states will be gradually encouraged to undertake procurement at their level for which the MoH&FW has framed the following guideline document:

Governance and Accountability Action Plan for Centrally Sponsored Health and Family Welfare Programs, Ministry of Health & Family Welfare, Government of India

Introduction:

The Ministry of Health and Family Welfare (MOHFW) is fully committed for ensuring better competition and transparency in procurement and supply of health sector goods and services required for delivery of quality services in all its programs. An Empowered Procurement Wing (EPW) has been established in MOHFW to support this process. To strengthen the capacities of the EPW in all aspects of procurement, the Department for International Development (DFID) is funding Technical Assistance.

Scope and Purpose:

The MOHFW has developed this Governance and Accountability Action Plan (GAAP), in consultation with the pooling partners (the Bank, DFID and UNFPA), to address critical operational concerns in Bank and pooled partner funded procurement of health sector goods and services.. The key issues and actions to address these concerns are included in the matrix below.

The GAAP applies to all centrally sponsored health and family welfare programs supported by the Bank and the other pooling partners, articulating the specific roles and responsibilities of different stakeholders (public, private and civil society institutions) in ensuring timely supply of quality commodities at a competitive price.

The GAAP will be strengthened, as necessary, based on risks identified and the recommendations of the RCH I investigations, the DIR, the procurement review by the EPW consultant, and the report on the quality and quantity of pharmaceuticals and medical goods.

The Bank financed "Food and Drugs Capacity Building project (Credit No. 37770)" would also support some of the broader issues related to strengthening of regulatory institutions especially effective implementation of GMP in the pharmaceutical sector as envisaged under the GAAP.

Issue	Proposed actions	By When	Person / agency responsible for implementation
I. Improving GMP certification process for pharmaceuticals	▪ Making WHO GMP (TRS 863) certification mandatory for ICB ▪ Pending new certification procedures (see next bullet) ensuring 100% post certification of all successful bidders recommended for award for the contract on the basis of existing WHO GMP certificates. ▪ (a) Issuing WHO GMP certificates in future only after a satisfactory joint inspection by the centre, state and an independent expert; and (b) carrying out random post WHO GMP certification audits (covering about 10% awards in each year). ▪ Making list of companies with valid WHO GMP certificates available on public domain. ▪ Agreeing on actions for GMP certification process and implementation arrangements satisfactory for pooling partners for non-ICB procurement of pharmaceuticals and medical supplies under pooled financing.	▪ Implemented ▪ Implementation will start from first Bank financed project after the date of this plan ▪ A panel of six independent experts has been identified in August 2005 and this panel will be updated on a regular basis with the inclusion of experts adequately covering all regions of the country. ▪ The GOI has disclosed the list of over 600 manufactures in February 2006 at the website of Central Drug Standards Organization. ▪ Completing the agreed actions and incorporating recommendations from the detailed implementation review in the GAAP will make non-ICB procurement eligible for pooled financing.	▪ Drugs Controller General of India ▪ Joint Secretary and Project Director, Food and Drugs Capacity Building Project ▪ Joint Secretary and Project Director, Food and Drugs Capacity Building Project

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Issue	Proposed actions	By When	Person/agency responsible for implementation
II. Increasing competition and mitigating collusion	▪ Finalizing future lot size, estimated prices and qualification criteria for procurement of pharmaceuticals and medical supplies based on market surveys about availability of products, prices and production capacities of manufactures.	(Ongoing) ▪ Based on "tool kit" developed by the Bank, the DFID has awarded the contract for market surveys and the results from first round are expected by	▪ EPW, MOHFW
	▪ Including a qualification requirement of minimum share of at least 20% revenue to be derived from non-Bank financed contracts in bid documents.	▪ Include qualification requirement immediately and implementation to start from the first Bank financed project after the date of this plan.	▪ EPW, MOHFW
	▪ Seeking "list of references" in the form of an affidavit in case of supplies made to public sector in past contracts. In the case of supplies made to private sector in the past, affidavit as well as supporting evidence will be sought. However, no bid would be rejected on the basis of non submission of documents on past performance above referred to.	▪ The MOHFW will verify the authenticity of referred documents on past performance only for the successful bidder ▪ Implementation to start from first Bank financed project after the date of this plan.	▪ EPW, MOHFW
	▪ Including "independent experts" in the bid evaluation process.	▪ Implemented	▪ EPW, MOHFW
	▪ Sharing record of public opening of bids for all contracts with the Pooling Partners within 2 working days.	▪ Effective immediately, starting with first bids for FY 2005-06. ▪ Implementation to start from first Bank financed project after the date of this plan.	▪ EPW, MOHFW
	▪ Ensuring payment within 30 working days of receiving the bill with supporting documents from the suppliers or communicating deficiency in the Bill within 15 working days.	▪ Effective as of April 19, 2005. ▪ Implementation to start from first Bank financed project after the date of this plan.	▪ EPW, MOHFW
	▪ Establishing clear and concise bid evaluation criteria.	▪ Effective as of April 19, 2005. ▪ Implementation to start from first Bank financed project after the date of this plan.	▪ EPW, MOHFW
	▪ Evolving generic and broad technical specifications	▪ MOHFW is establishing a database of generic technical specifications for commonly procured equipment which will be disclosed at their website by	▪ EPW, MOHFW

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Issue	Proposed actions	By When	Person / agency responsible for implementation
III. Strengthening procurement implementation and contract monitoring	▪ Strengthening procurement supervision capacity at Empowered Procurement Wing (One JS, Two Directors and 10 Dy/ Asst. Directors with support staff and infrastructure) including engagement of an external consultant firm selected through international selection process for capacity building and development of procurement monitoring and complaints data base.	▪ Underway ▪ The MOHFW has constituted an Empowered Procurement Wing (EPW) with specific Terms of Reference. ▪ An International external consultant firm (Ms. Crown Agents) was selected to support EPW in the implementation of the GAAP. This consultancy is being supported by DFID TA. ▪ The first training in health sector goods procurement for the EPW staff, procurement consultants and state procurement officers was organized during January 16-25, 2006. A series of similar programs at regional and state levels are being planned.	▪ National Program Coordination Committee, National Rural Health Mission (NRHM) ▪ EPW, MOHFW
	▪ Establishing a "procurement monitoring and complaints" database* to monitor adherence to the standards listed in RCH Program Procurement Manual. This database would be online with restricted access.	▪ Manual database established in MOHFW and computerized database is expected by March, 2007	▪ EPW, MOHFW
	▪ Developing and deploying a software for the early identification of indicators of fraudulent or corrupt practices.	▪ To be completed by July 1, 2008	▪ EPW, MOHFW

* The data base should specifically allow: (i) complete and adequate record keeping and retrieval of all documents supporting each bid including unit prices quoted and prices at which contracts are awarded; (ii) Quantities and dates of supply as per the contract and actual; (iii) Rejection of supplies, if any, with reasons; (iv) Date bill received, value, and date of payment and (v) complaints received, responses sent and actions taken by dates.

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Issue	Proposed actions	By When	Person / agency responsible for implementation
IV. Handling procurement complaints	▪ Updating the "Procurement monitoring and complaints" data base on a monthly basis.	▪ Manual database established in MOHFW and computerized database to be operational by March, 2007	▪ National Program Coordination Committee, National Rural Health Mission (NRHM) ▪ C P U, MOHFW
	▪ Listing and discussing all complaints received and actions taken in the bid evaluation report.	▪ Implementation to start from first Bank financed project after the date of this plan	
	▪ Providing details of the administrative process for the disqualification of bidders who engage in misrepresentation in the bid process or in contract execution.	▪ Implemented	
	▪ Reporting the status of investigation of complaints and measures taken in monthly progress reports to the National Program Coordination Committee of the NRHM.	▪ Agreed. ▪ Implementation to start from first Bank financed project after the date of this plan.	
	▪ Sharing complaints status with the pooling partners once every quarter	▪ Agreed. ▪ Implementation to start from first Bank financed project after the date of this plan.	
V. Disclosing Information and promoting oversight by the civil society	▪ Making publicly available all annual procurement schedules promptly after finalization on the MOHFW website.	▪ Agreed. ▪ Implementation to start from first Bank financed project after the date of this plan.	▪ National program coordination committee, NRHM ▪ EWO, MOHFW
	▪ Posting all bidding documents and requests for proposals on the MOHFW website.	▪ Agreed. ▪ Implementation to start from first Bank financed project after the date of this plan.	
	▪ Making available to any member of the public promptly upon request all shortlist of consultants and in case of pre-qualification, list of pre-qualified contractors and suppliers.	▪ Agreed. ▪ Implementation to start from first Bank financed project after the date of this plan.	
	▪ Disclosing information on prequalification, all bids received reasons for rejections, and award of contracts at the MOHFW website and sharing the same with the pooling partners to disclose at their preferred Websites.	▪ Agreed. ▪ Implementation to start from first Bank financed project after the date of this plan.	

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Issue	Proposed actions	By When	Person/agency responsible for implementation
	▪ Posting annual progress and Mid Term Review reports of the program on the MOHFW website.	▪ Agreed. ▪ Implementation to start from first Bank financed project after the date of this plan.	
	▪ Moving to e-procurement	▪ Agreed. ▪ Implementation to start from first Bank financed project after the date of this plan.	

Procurement Arrangements

Implementation of the various National Programs in the Health Sector entails procurement of contraceptives, drug-kits, vaccines, drugs, equipment, hiring of experts for specific tasks, and civil works etc. These "Guidelines for Procurement" briefly provide the essential information and step-by-step procurement procedures to achieve objectives. However, the states may be required to customize the procedure described herein to meet the requirements of existing system preferably by way of development of a state specific operation manual.

For additional guidance on this subject, DGS&D manual can be referred to. DGS&D booklets governing the contract and standard tender forms e.g Bank Guarantee for EMD, bank guarantee for performance security, performance statement etc. are available on **www.dgsnd.gov.in** or **www.dgsnd.nic.in**.The choice of procurement procedures may be decided by the executive committee of the state for the entire procurement or for each procurement on a case-to-case basis.

This document is intended for the procurement officer to use a uniform system of procurement in all the states. It is also intended to guide the Procurement Service Agents (PSAs), wherever hired, to understand the procurement procedure. The rights and obligations of the purchaser and the contractor of goods and works are governed by the tender documents and by the contracts signed by the purchaser with the contractor and not by these guidelines.

The aim of the procurement process should be to ensure that necessary supplies of the right quality are obtained at reasonable cost through a fair and transparent system.

1. Procurement plan and procedures

When making procurements, specific budget provision should be available for meeting the expenditures in the financial year in which it is to be incurred.

a. **Procurement plan**

- Preparation of a procurement plan is essential. A procurement plan covering civil works, equipment, goods, consultancy services and resource support shall be prepared on a firm basis for the first year of the program and on a tentative basis for the subsequent years.
- Procurement plans shall be prepared every year for proper monitoring and execution.
- Procurement plans shall be prepared contract-wise.
- Method of purchase shall be based on the value of the contract, urgency of the demand, type of goods/services, and availability of different sources of supply etc.
- Limit of value per contract applicable to the particular procurement procedure shall be strictly adhered to.
- It shall be ensured that the procurement is based strictly on actual need.

b. **Procurement procedure**

The procurement procedure broadly consists of the following steps:

- Assessment of requirement
- Deciding procurement strategy including technical specifications
- Mode of procurement
- Preparation of tender document
- Advertisement of the tender
- Issue of tender documents
- Opening of the tender
- Evaluation of the tender
- Clearance of World Bank/DFID, whenever required
- Award of contract
- Notification of delivery to consignee
- Inspection and testing notification of delivery to consignee
- Receipt of consignment
- Acceptance and storage of the consignment
- Resolution of disputes, if any

2. Forecasting / assessment of the requirement

Bulk requirement of the stores for state level/district level should be assessed prior to the beginning of the financial year to get competitive prices. Action for procurement should be initiated in accordance with the purchase procedures. While forecasting the requirement the following factors should be considered:

- Average time period required in complete procurement cycle. In some cases; it can take 8 to 12 months to complete the procurement cycle.
- The trends in usage at the time of requirement.
- Current stock, where the stock is located, when the product is due to reach the expiry date and what the projected time scale is for distribution.
- Storage capacity for receiving the bulk consignment. In case the storage capacity is limited, the procurement/supply of commodities should be phased over time rather than arriving as one consignment.
- List of consignees and their storage capacity.
- The problems, if any, encountered with procurement and distribution over the last few years.

Consolidating several program procurement requirements can result in savings through price discounts as well as reduce the administrative costs associated with having to process multiple orders.

3. Deciding on procurement strategy

It is important to agree on the procurement strategy before initiating the tendering. For example, purchase of drugs having limited shelf life shall require a different procurement strategy than purchase

of hospital beds, for example. Issues like pre-qualification of suppliers to reduce the procurement cycle time in the case of life-saving drugs and having multiple supply lines for essential items should also be considered. Similarly for civil works, options like work contract on lump-sum basis or based on bill of quantities can be explored. The procurement strategy should cover:

- Key objectives of the procurement for the project
- Chosen procurement option
- Chosen procurement route (Open, Negotiated, Restricted)
- Key milestones (check that enough time will be allowed for negotiations, if relevant.)
- Key documents (e.g. requirements specification)

Key factors influencing the procurement strategy relate to the degree of complexity, innovating and uncertainty about the requirement, together with the time needed to achieve a successful outcome.

4. Mode of procurement

The methods of procurement normally followed are:

- Global tender/international competitive bidding (ICB)
- Open advertised tender/national competitive bidding (NCB)
- Limited tender (National /International)
- Shopping (National/International)
- Single tender/direct contracting
- Procurement of civil works through PRIs

A. Global tender / International Competitive Bidding (ICB)

This method is generally adopted where the supplies need to be imported and foreign firms are expected to participate, irrespective of the value. In the case of RCH procurement, this method is adopted when the estimated cost of the procurement is more than the equivalent of US $ 1,000,000 for goods and US $ 10,000,000 for works.

Requirement

- Apart from wide publicity nationally, invitation to bid shall also be forwarded to embassy and trade representatives of the countries of likely suppliers/contractor of the goods and works and also to those who have expressed interest in response to the general procurement notice.
- Invitation to bid will also be published in UNDB and DgMarket in cases where estimated value of the contract is more than the equivalent of US $ 200,000. This publication will be arranged by the World Bank/DFID.
- Use of standard tender document.
- Sale of bidding documents should start only after publication of invitation to bid.
- Bidding period 45 to 90 days from the date of start of sale of bidding document.
- Other procedures for global tender will broadly be same as that of open advertised tender.

B. Open advertised tender / National Competitive Bidding (NCB)

- Open tender is the competitive bidding procedure normally used for public procurement in the country and by their nature or scope may be the most efficient and economical way of procuring goods or works. The procedures shall provide for adequate competition in order to ensure reasonable prices. The method to be used in the evaluation of tenders and the award of contracts shall be made known to all bidders and not be applied arbitrarily.
- In the case of RCH procurement open tender is normally adopted where the contract value is less than US $ 1,000,000
- Civil works, and also goods, could be procured under contracts awarded in accordance with the procedures prescribed under open tenders.
- Various steps involved in procurement under open tender procedure have been enumerated in clause I (b).
- Notification/Advertising: Timely notification of bidding opportunities is essential in competitive bidding:
  - Invitation to bid shall be published in daily newspapers with wide circulation all over India, in at least one national English and one regional language daily. If the advertisement is for more than one item, it should also be indicated whether the evaluation would be item-wise or as a package. The advertisement should also be placed on the website of the department.
  - If a condition in the invitation for tender is that earnest money is to be deposited by the supplier/ contractor, the bid of a supplier / contractor not complying with this requirement, shall be rejected. In the case of deposit of earnest money, the state's existing procedure may be followed. However, it is desirable that a level playing field be created in this regard.
  - In a package, the earnest money is indicated taking into account all the items. This cannot be changed later on. Once it is decided that the contract is for a package the earnest money for that package is to be indicated and the same cannot be changed according to each item.
  - The last date for receipt of tender shall be the day following the date for close of sale of tender documents.
  - Tendering period shall not be less than 30 days from the date of start of sale of tender documents.
  - Tenders can be sold from different places but the tenders may be received at one place to avoid problems arising out of late/delayed tenders. Tenders should normally be opened half an hour after the deadline for receipt.
- **Tender documents**: The state government's standard tender documents should be used. Sale of tender documents should begin only after the publication of notification for tender in the newspapers. The tender documents shall furnish all information necessary for a prospective bidder to prepare a tender for the goods and works to be provided. Tender documents should be made available to all who seek them after paying the requisite fees, if any, regardless of registration status and they should be allowed to bid.

  Clarity of tender documents: Tender documents shall furnish clearly and precisely the work to be carried out, the location of the work, the goods to be supplied, the place of delivery or installation, the schedule for delivery or completion, specification/technical specification, minimum performance

requirements, warranty and maintenance requirements, if any, and the method of evaluation. The basis for tender evaluation and selection of the lowest technically suitable and evaluated tender shall be clearly outlined in the instructions to tenders and / or the specifications.

Tender documents should state clearly whether the bid prices will be fixed or whether price adjustments will be made to reflect any change in major cost components of the contract.

- **Standards and technical specifications**: The implementing agency shall specify the generally accepted standards of technical specifications. Unbiased technical specification shall be prepared with no mention of brand names and catalogue numbers. In case the item to be procured is not covered under BIS or I.P. and specifications are to be framed, these may be prepared by a committee of experts associated with the trade, if required. The functional performance, design, quality, packaging and additional requirements should be clearly spelt out in the specifications. The specifications should be generic and should not appear to favor a particular brand or supplier.

  Technical specifications, bill of quantities and civil drawings should be prepared before tendering. Clear specifications for the articles to be procured should be drawn up in every case. No deviation from the specifications should be allowed after opening of tender.

- **Validity of tender**: Bidders shall be required to submit tenders valid for the period specified in the tender documents. Normally, the bid validity period shall not exceed 90 days.

- **Earnest money**: Earnest money of normally 2% of the estimated cost of the item or works shall be the appropriate amount, which should be indicated, as a specific amount. The earnest money shall be in the form of a demand draft / bankers' cheque/bank guarantee from a scheduled bank, which should be valid up to 45 days beyond the validity period of the tender. The earnest money of unsuccessful bidders shall be refunded soon after the final acceptance of tenders. The earnest money shall be forfeited in the event of withdrawal of the tender within the original validity once submitted or in case a successful bidder fails to execute necessary agreement within the period specified.

- **Pre-bid conference**: A pre-bid conference (date/venue to be indicated in the bid document) may be arranged wherein potential bidders may meet the representatives of the implementing authority to seek clarifications on the tender documents. Copy of minutes of the pre-bid conference should be furnished to the bidders who have already purchased the bid documents and also sold along with the bid document to the parties purchasing the document subsequent to the pre-bid conference.

- **Terms and methods of payment**: Payment terms shall be in accordance with the practices applicable to the specific goods and works. Tender documents should specify the payment method and terms offered.

- **Conditions of contract**: The contract documents shall clearly define the scope of work to be performed, the goods to be supplied, the rights and obligations of the implementing agency and of the supplier or contractor, and the functions and authority of the engineer, architect, or construction manager, (if one is employed by the implementing agency) in the supervision and administration of the contract. Special conditions related to specific items should also be clearly specified in the tender document.

- **Performance security deposit**:
  - Tender documents for works and goods shall require security in an amount sufficient to protect the implementing agency in case of breach of contract by the contractor. This shall be in the form of a

bank guarantee or any other instrument and the amount should be specified in the tender document. The amount of performance guarantee shall normally be 5% of contract price (valid till 28 days from the date of expiry of defect liability period or the guarantee/warranty period as the case may be).

- The performance security deposit shall be refunded within one month of the completion of supply of goods/works. It will, however, be refunded after the expiry of guarantee/warranty period (as mentioned above) where there is condition of guarantee/warrantee.
- The performance security deposit shall be forfeited in case any terms and conditions of the contract are infringed upon or the bidder fails to make complete supply satisfactorily or complete the work within the delivery/completion period agreed in the contract.

- **Retention money**: In contracts for works, normally 5-10% of contract price shall be recovered for retention money. 50% of such money shall be retained till completion of the whole work and 50% shall be retained till the end of defects liability period.
- **Liquidated damages**: Provisions for liquidated damages shall be included in the conditions of contract when delays in the delivery of goods, completion of works, failure of the goods or works to meet performance requirements would result in extra cost, or loss of revenue or loss of other benefits to the implementing agency.
- **Tender opening:**
  - The time for the tender opening should be at least half an hour after the deadline for receipt as discussed above.
  - Tenders shall be opened in public. The bidders or their representatives shall be allowed to be present at the time of opening of bids.
  - All tenders received should be opened. No bid should be rejected at bid opening except for late tenders. Late tenders shall be returned to the bidders unopened.
  - The name of the bidder and total amount of each bid along with important conditions like excise duty, sales tax, delivery terms, delivery period, special conditions, if any, shall be read out at the time of bid opening.
  - Spot comparative statement (minutes of bid opening) must be prepared by the bid opening official and should be signed.
- **Confidentiality:** After the public opening of tenders, information relating to the examination, clarification, and evaluation of tenders and recommendations concerning awards shall not be disclosed to bidders or other persons not officially concerned with this process until the successful bidder is notified of the award of the contract.
- **Examination of tenders**.

  a. The implementing agency shall ascertain whether the tenders
     - Meet the eligibility requirements specified
     - Have been properly signed
     - Are accompanied by the required earnest money and valid for the period specified in the tender document

- Are substantially responsive to the tender document
- Have the technical and financial capability to successfully execute the contract. For ensuring financial capacity a minimum turnover requirement should be indicated in the bid document
- Are otherwise generally in order.

b. If a bid is not substantially responsive, that is, it contains material deviations from or reservations to the terms, conditions, and specifications in the tender documents, it shall not be considered further. The bidder shall not be permitted to correct or withdraw material deviations or reservations once tenders have been opened.

- **Tender evaluation and comparison**
  - The purpose of tender evaluation is to determine the cost to the implementing agency of each tender in a manner that permits a comparison based on its evaluated cost. The tender with the lowest evaluated cost and substantially responsive, but not necessarily the lowest submitted price, should be selected for award.
  - The bid price read out at the bid opening shall be adjusted to correct any arithmetical errors for the purpose of evaluation.
  - Evaluation of tenders should be made strictly in terms of the provision in the tender documents to ensure compliance with the commercial and technical aspects.
  - The conditional discounts offered by the bidder shall not be taken into account for evaluation.
  - The past performance of the suppliers/ contractor should also be taken into account while evaluating the tenders. (this should also be indicated in the bid document)
  - The implementing agency shall prepare a detailed report on the evaluation and comparison of tenders setting forth the specific reasons on which the recommendation is based for the award of the contract.
- **Negotiation**

  Negotiation after tenders are opened should ordinarily be discouraged. However, in exceptional cases it may be undertaken only with the lowest evaluated responsive bidder (L-1) as per the state's procurement procedure. In case the rates even after negotiation are very high, fresh tenders should be invited. While fixing the date for negotiation, it should be ensured that sufficient time is allowed to the bidders to attend the same.
- **Extension of validity of tenders**

  As far as possible, the contract should be finalized within the original validity of the offers mentioned in the tender. An extension of bid validity, if justified by exceptional circumstances with the approval of next higher authority, shall be requested in writing from all bidders (of valid tenders only) before the expiry date. Bidders shall have the right to refuse to grant such an extension without forfeiting their earnest money, but those who are willing to extend the validity of their bid shall also be required to provide a suitable extension of earnest money.

- **Post-qualification of bidders**

  If bidders have not been pre-qualified, the implementing agency shall determine whether the bidder whose bid has been determined to offer the lowest evaluated cost has the technical capability and financial resources to effectively carry out the contract as offered in the bid. The criteria to be met shall be set out in the tender documents, and if the bidder does not meet them, the bid shall be rejected. In such an event, the implementing agency shall make a similar determination for the next-lowest evaluated bidder and so on.

- **Repeat orders**

  Purchases under open tender method may be increased as per the prevailing state procedure up to *15%* of the quantity originally ordered through repeat orders after recording reasons provided that such orders shall be given before the date of the expiry of last supply made and also subject to the condition that prices have since not reduced and purchases were required urgently.

- **Rejection of all tenders**
  - Tender documents usually provide that the implementing agency may reject all tenders. Rejection of all tenders is justified when none of the tenders are substantially responsive or when negotiations with the L1 bidder has failed. However, lack of competition shall not be determined solely on the basis of the number of bidders. If all tenders are rejected, the implementing agency shall review the causes justifying the rejection and consider making revisions to the conditions of contract, design and specifications, scope of the contract, or a combination of these, before inviting new tenders.
  - If the rejection of all tenders is due to lack of competition, wider advertising shall be considered. If the rejection is due to most or all of the tenders being non-responsive, new tenders may be invited.
  - Rejection of all tenders and re-inviting new tenders, irrespective of value shall be referred to the **competent authority for approval after examining whether technical specifications need any change.**

C. Limited tender (National / International)

Limited tendering is nothing but NCB done by direct invitation to selected potential suppliers of proven capacity-cum-capability (from at least two different countries in case of international limited tender) without open advertisement but enough to ensure receipt of competitive bids.

This procedure could be adopted where:

- There are only a limited number of suppliers of the particular goods or services
- Demand is urgent in nature
- Exceptional reasons exist justifying departure from full Advertised Open Tender.

Other procedures under limited tender will be same as that of open advertised tender.

Rate contracts of Directorate General of Suppliers and Disposals (DGS&D) and rate contracts of state governments shall also be an appropriate method under limited tender system. The purchaser shall, however, check that the rate contracts are representative of market price and are not obsolete.

In all such cases, approval of the competent authority to dispense with open advertised tender should be taken.

D. Shopping

- Shopping is a procurement method based on comparing price quotations obtained from several suppliers/contractors, usually at least three, to ensure competitive prices.
- Goods including drugs and equipment, and civil works estimated to cost below the financial ceiling prevailing in states or less per contract may be procured under the shopping.
- It is an appropriate method for procuring readily available off-the-shelf goods or standard specifications commodities of small value or simple civil works of small value.
- Approval of competent authority may be obtained for items of goods to be purchased or civil works to be constructed/renovated/repaired along with specifications, estimated costs and agencies from whom quotations should be invited.
- The requests for quotations shall indicate the description, specification and quantity of the goods and terms of delivery or specification of works, as well as desired delivery or completion time and place. If the quotations are called for more than one item/works, it should also be indicated whether the evaluation would be for each item or for each civil work or as a package.
- Quotations could also be obtained by telex or facsimile. The terms of accepted offer shall be incorporated in a purchase order or brief contract.
- Rate contracts entered into by DGS&D and by state governments will be acceptable for any procurement under shopping.

E. Single tender / Direct contracting

- The single tender system may be adopted in case of articles including drugs and equipment, which are specifically certified as propriety in nature, or where only a particular firm manufactures the articles demanded or in case of extreme emergency.
- The single tender system without competition shall be an appropriate method under the following circumstances:
  - Extension of existing contracts for works or goods awarded with the prescribed procedures, justifiable on economic grounds
  - Standardization of equipment or spare parts to be compatible with existing equipment may justify additional purchases from the original supplier
  - The required item is proprietary and obtainable only from one source
  - Need for early delivery to avoid costly delays
  - Works are small and scattered or in remote locations where mobilization costs for contractors would be unreasonably high; and
  - In exceptional cases, such as in response to natural disasters.

F. Procurement of civil works through Panchayati Raj Institutions (PRIs)

For small works of value up to Rs.6 lakh, the states may decide to get these executed through PRIs wherever considered appropriate. In the RCH Phase II, construction/repair of sub-centers would fall within this threshold limit. Wherever works are entrusted to PRIs, it should be ensured that these institutions do manage to obtain contributions from the community. The extent of such contribution may be decided by the states. It should also be ensured that adequate arrangements for supply of standardized designs and

preparation of estimates, supervision of construction, maintenance of quality control, and rendering appropriate accounts are in place.

G. Award of contract

The implementing agency shall award the contract, within the period of the validity of tenders, to the bidder who meets the tender conditions in all aspects, has the necessary technical capability and financial resources and whose bid is substantially responsive to the tender documents and has the lowest evaluated cost. The purchaser can, if so desired, depute a team of 3-4 officers to the premises of the manufacturer to whom the contract is proposed to be awarded to satisfy itself that the manufacturer has capability to produce the required quantity and also the necessary quality testing and assurance facilities to meet the required standards. Based on the report of this committee, the purchaser may decide to award the contract to the successful bidder offering the lowest or reasonable price after approval of the appropriate authority.

Single tenders should also be considered for award, if it is determined that publicity was adequate, bid specification/conditions were not restrictive or unclear, and bid prices are considered reasonable.

H. Inspection, sampling and testing procedure

The inspection authority and procedure for sampling and testing should be clearly specified in the tender document. A purchaser must select a set of accredited testing laboratories for testing the samples accordance with ISO requirements. The purchaser should request a written confirmation from the supplier that the results of the testing laboratory chosen for qualification and compliance testing will be accepted by the supplier. The name of the testing lab should be incorporated in the tender document. The authority that will collect random samples should also be specified.

The purchaser will decide whether 100% pre-dispatch inspection is required at the manufacturer's premises, depending on the items to be purchased. Sometimes it is important to verify that each manufactured batch complies with the specifications before it is finally dispatched to the consignee. When a consignment is ready for dispatch, the supplier will inform the purchaser that the consignment is ready for the testing. The purchaser then instructs the inspection agency to carry out the inspection viz. visit the supplier's factory and draw samples from the batches offered for inspection, in accordance with sampling guidelines. The inspection agency will send the samples directly to the designated testing laboratory chosen by the purchaser for quality testing. Based on the results of the test, the batch may be cleared for dispatch. To avoid later dispute on the testing results, a representative of the supplier may be invited to witness the testing of the sample at the laboratory, if feasible.

In case of procurement of kits, where the kits are assembled by another party before supplying the final kits to the purchaser, the inspection and quality control procedures should be clearly mentioned in the tender document.

The above procedure applies mainly for procurement of drugs. In case of procurement of other goods, they may be inspected on arrival at purchaser's premises for any possible damage/defect either in manufacturing or in transit. In case of complex capital goods, the inspection at manufacturers' premises may also be required.

If the stores do not meet the performance requirement, they should not be accepted. If there are any disputes or doubts about the quality of the products, a procedure of resolution of dispute may be followed as per the terms of the contract.

I. Notification of delivery to consignee

Notification of delivery or dispatch in regard to each and every installment shall be made by the supplier to the consignee through a packing account quoting the number of the supply order and the date of dispatch of the stores. All packages, containers, bundles and loose materials part of each and every installment shall be fully described in the packing account and full details of the contents of the packages and quantity of materials shall be given to enable the consignee to check the stores on arrival at destination. The railway receipt, consignment note or the bill of the lading, if any, should be drawn in the name of the consignee and should be sent to him by registered post acknowledgement due immediately on dispatch of stores, quoting the No. (s) and date (s) of the corresponding Inspection Note(s) in relation to the stores covered by the said Railway Receipt, the consignment note or the Bill of Lading, as the case may be. The contractor shall bear and reimburse to the purchaser, demurrage charge, if any paid by the reasons of delay on the part of the supplier in forwarding the railway receipt, consignment note or bill of lading.

J. Receipt of consignment

In case of imported stores, the purchaser should be aware of the custom clearance requirement prior to issuing the contract. A clear procedure (i.e. who will clear the goods and pay the duties, loading and unloading of the consignment, transport of the consignment to the premises of the consignee etc.) for custom clearance should be specified in the contract.

At the time of the delivery of the stores, the consignee should accept the stores on “said to contain” basis and should issue the provisional receipt certificate in the standard format (sample attached). After opening the package and making a detailed examination of the stores the consignee will issue the final acceptance certificate if he is satisfied with the quality of the goods. Notwithstanding the pre-qualification or the inspection of the goods/services by the inspection agency, the consignee has the right to further inspect and test the goods but within a reasonable time (say up to 60 days) and if the goods fail to meet the specifications given in the contract, he should reject the goods and ask the supplier to replace the goods or rectify the defects.

K. Storage

Experience has demonstrated that properly packed, good quality goods (except some drugs and vaccines or specific items) do not deteriorate when stored at average temperature found in tropical climates.

Air-conditioning is generally not necessary if the goods are properly packaged and stored in a clean, dry and well-ventilated environment.

If quality assurance measures have been strictly followed during the manufacturing process; the conditions of warehousing and storage play a major role in ensuring that quality goods received reach final users in good condition. They should be left in their original packaging while in storage. The batch number and marking on the cartons should be recorded to ensure that all batches are traceable and distributed on a first in first expiry basis. The drugs, which require special storage such as maintaining proper temperature, should be stored in appropriate condition.

L. Resolution of disputes

The dispute resolution methodology should be very clearly indicated in the contract document. As far as possible, disputes may be resolved with mutual agreement between purchaser and buyer through alternate dispute resolution methods to avoid going through arbitration and litigation stage.

There a number of possible causes of disputes during the execution of contract. These may involve:

- Interpretation of the terms and conditions of the contract
- Delay in delivery/completion of the works
- Delay in release of payment
- Independent laboratory test results
- Condition of the items on arrival at consignee and after delivery
- Rate of the items, variation in quantity in civil works contract etc.
- Design/specification issue

Disputes over laboratory results

Disputes over product acceptance usually arise when independent testing determines that the product is not in compliance with the required specification or standard. It is also possible for a manufacturer to dispute a decision made by the inspection agency regarding product packaging or appearance.

In most cases, manufacturers accept the results of independent laboratories and replace batches that have been rejected. When manufacturers do not accept the test results, they usually present test results or other evidence to suggest that the independent laboratory test are incorrect and do not accurately represent the quality of the product tested. Procedures for dealing with such disputes should be covered in the contract.

Decision on re-testing

Re-testing should only be undertaken when there is reasonable evidence that the laboratory has made a mistake. Before considering a re-test all the available data should be reviewed. If a manufacturer disputes a test result, the following issues should be considered in deciding whether to allow a re-test:

- What is the margin by which the product has failed to comply?
- Is the manufacturer's history of production for the client a good one?
- What is the nature of the difference between the manufacturer's and the laboratory's test results? Where appropriate, the laboratory should keep the failed samples of goods so that the manufacturer can examine them.
- Samples of the failed batch could be sent to the designated appellate testing laboratory as specified in the contract.

The amount of information available for review depends on the type of test.

In all cases, the manufacturer should bear the cost of a retest, unless it can be demonstrated that it is likely that the laboratory results; it is always desirable to invite the representative of the supplier to witness the testing of samples.

M. Laws governing the contract

- The contract shall be governed by the laws of India in force.
- The courts of the place from where the acceptance of tender has been issued shall alone have jurisdiction to decide any dispute arising out of or in respect of the contract

- Irrespective of the place of delivery, the place of performance or place of payment under the contract or the place of issue of advance intimation of acceptance of tender, the contract shall be deemed to have been made at the place from where the acceptance of the tenders have been issued.

N. Arbitration (NCB/Shopping)

- In the event of any question, dispute or difference arising under the contract conditions or any special conditions of contract, or in connection with the contract (except as to any matters the decision of which is specially provided for by these or the special conditions) the same shall be referred to the sole arbitration of an officer, from the department other than the department who has decided the contract having sufficient knowledge of Law, appointed to be the arbitrator by the purchaser. The award of the arbitrator shall be final and binding on the parties to this contract.
- In the event of the arbitrator dying, neglecting or refusing to act or resigning or being unable to act for any reason, or his award being set aside by the court for any reason, it shall be lawful for the purchaser to appoint another arbitrator in place of the outgoing arbitrator in the manner aforementioned.
- It is further a term of the contract that no person other than the person appointed by the purchaser as aforementioned should act as arbitrator and that, if for any reason that is not possible, the matter is not to be referred to arbitration at all.
- The arbitrator may from time to time with the consent of all parties to the contract, enlarge the time for making the award.
- Upon every and any such reference, the assessment of the costs incidental to the reference and award respectively shall be in the discretion of the arbitrator.
- Subject as aforesaid, the Arbitration Act, amended up to date and the rules there under and any statutory modification thereof for the time being in force shall be deemed to apply to the Arbitration proceedings under this clause.
- If the value of the claim in a reference exceeds Rs.1 lakh the arbitrator shall give reasoned award.
- The venue of arbitration shall be the place from which formal Acceptance of Tender is issued or such other place as the purchaser at his discretion may determine.

  Suitable cause may be incorporated in the tender enquiry to obtain the consent of the bidder to accept the arbitration clause.

O. Extension of contract

Normally, the contract once awarded should not be extended. Under exceptional circumstances, extension of existing contracts up to 50% of the original contract value may be considered, if it is justifiable on economic grounds.

P. Compliant redressal mechanism (also applicable to service procurement)

In order to deal with the complaints received from the contractors/suppliers effectively, a compliant handling mechanism should be available at the national level as well as at state level, and immediate action should be initiated on receipt of complaints to redress the grievances. All complaints should be handled at a level higher than that of the level at which the procurement process is being undertaken and the allegations made in the complaints should be thoroughly enquired into. If found correct, appropriate remedial measures should be taken by the appropriate authorities.

In case any individual staff is found responsible, suitable disciplinary proceedings should be initiated against such staff under the applicable government conduct rules. The existing provisions under the Indian law including the instructions of central vigilance commission should be followed in this regard.

Q. Procurement audit (also applicable to service procurement)

All the procurements made by the central and state governments are subject to post-audit either by Comptroller and Auditor General (CAG)/State Audit Departments and by the Development Partners (DPs). Hence, all the documents related to the procurement should be filed and kept systematically and safely.

Hiring of consultants

Background

Definition of services includes training, workshops, IEC activities (printing or distributing material through an agency), contraceptive distribution service, research and studies, hiring of procurement agents, hiring of consultants, NGO services, PPP agreements and other similar contracting.

General consideration

- High-quality services
- Economy and efficiency
- Give qualified consultants an opportunity to compete
- Encouraging the development and use of national consultants
- The importance on transparency in the selection process

The procedures to be followed in all cases are given in brief below

Steps

- Establish the need for the assignment and outsourcing the service
- Preparation of the terms of reference (TOR)
- Preparation of cost estimate and the budget
- Agreeing on the contracting strategy
- Advertising (for short-listing of the firms when the purchaser has no knowledge about the firms who could take up the assignment)
- Preparation of the shortlist of consultants
- Preparation and issues of request for proposal (RFP)
  - Letter of invitation (LOI)
  - Information to consultants(ITC)
  - Proposed contract
- Receipt of proposals
- Opening and evaluation of technical proposals
- Evaluation of financial proposal

- Combined evaluation of quality and cost
- Negotiations and award of the contract to the select firm

1. Preparation of the Terms of Reference (TOR)

The Terms of Reference should include:

- A precise statement of objectives
- An outline of the tasks to be carried out
- A schedule for completion of tasks
- The support/inputs provided by the client
- The final outputs that will be required of the consultant
- Composition of review committee (not more than three members) to monitor the Consultant's works.
- Review of the progress reports required from consultant
- Review of the final draft report
- List of key positions whose CV and experience would be evaluated

2. Preparation of cost estimate and the budget

The cost estimates or budget should be based on the assessment of the resources needed to carry out the assignment, staff time, logistical support, and physical inputs (for example, vehicles, office space and equipment). Costs shall be divided into three broad categories;

- Fee or remuneration;
- Reimbursable costs; and
- Miscellaneous expenses.

3. Contracting strategy

Before starting the tendering exercise, it is essential to agree on contract strategy viz. going for lump-sum or time based contract, individual versus firm, advertising versus internal short listing, terms of payments etc.

4. Advertising

In case a short list of 3-6 consultants cannot be drawn by the purchaser by its own knowledge, adverting through newspapers is the right way to compile the shortlist. Advertisement is issued asking the potential service providers to indicate their interest in the assignment and provide abridged CVs of the proposed team members, their previous experience in similar type of assignment and the financial statement of the organization through the balance sheets of the last 3 years. The advertising may be considered in the following media:

- Regional newspaper
- National newspaper

- International newspapers
- Technical magazines
- Purchasers' website

5. Short-listing

If the assignment has been advertised, the expressions of interest received shall be evaluated to arrive at shortlist of the consultants. In preparation of the shortlist first consideration shall be given to those firms expressing interest which possess the relevant qualification. The shortlists shall comprise six firms.

Government-owned enterprises can be considered for award of consultancy assignment. However, such enterprise directly under the administrative control of the purchasing department/organization should not generally be considered for such assignment.

6. Types of contracts

Various types of contracts are as under:

- Lump Sum - These contracts are used for assignments in which the content and the duration of the work is clearly defined. Payment is made upon delivery of outputs. The main advantage of this type of contract is that it is easy to administer. Examples of lump sum contracts include feasibility studies, environment studies, detailed design of a standard structure etc.
- Time Based - These contracts are used for assignments in which it is difficult to define the scope and the duration of the work to be performed. Payment is based upon an hourly, daily, or monthly rate, plus reimbursable expenses using actual expenses or agreed-upon unit prices. This type of contract provides for a maximum total payable amount that includes a contingency for unforeseen work and duration, price adjustment etc. Example of Time Based contracts include: preparation of data, complex studies, supervision of construction of construction of civil works, training assignments, advisory services etc.
- Percent contract relates to the fee paid to the consultant based upon the estimated or actual project construction cost or the cost of the goods to be procured or inspected. Percentage is established based upon market norm or standard practice in the industry. Example of percent contracts include: architectural services, engineering services, procurement services, inspection agents etc.

7. Request for Proposals (RFPs)

The RFP shall include:

- A letter of invitation (LOI), which will include evaluation criteria
- Information to consultants
- Terms of reference
- Draft of the proposed contract

A sample evaluation criterion is given below:

Evaluation Factors		Percent
Quality (Each should have a sub-criteria not exceeding three)	Experience	5 to 10
	Methodology	20 to 25
	Key Personnel*	55 to 60
	Transfer of Knowledge (if required)	5
Total		**100**

A minimum qualifying mark (approximately 70%) for technical proposal should be indicated in the RFP document.

*The individuals shall be rated in the following three sub-criteria, as relevant to the task:

a. General qualifications: General education and training, length of experience, positions held, time with the consulting firm as staff, experience in developing countries, and so forth;

b. Adequacy for the assignment: education, training, and experience in the specific sector, field subject, and so forth, relevant to the particular assignment; and

c. Experience in the region: Knowledge of the local language, culture, administrative system government organization, and so forth.

8. Opening and evaluation of proposals

The technical proposals are to be opened and evaluated based on the evaluation criteria given in the RFP document. The financial proposals of only those bidders who secure more than minimum qualifying marks in technical evaluation should be opened publicly in the presence of the technically qualified consultants who choose to attend.

9. Negotiations and signing of contract

If required, negotiations on technical and commercial aspects (if permitted by the state's guidelines) should be held with the lowest qualified bidder and on conclusion of the same, the contract should be signed.

Normally no penalties are imposed on the consultants, be it a firm or individual, for unsatisfactory performance or delay in completion of the assignment / service in the agreed time frame. It is hence suggested to do the performance evaluation of the consultant on completion of each assignment and keep the same in view while short-listing them for any future assignment.

10. Single source selection may be appropriate only if it presents a clear advantage over competition and on account of the following reasons:

- For tasks that represent a natural continuation of previous work carried out by the firm.
- Where a rapid selection is essential (emergency operation)
- For very small assignments (say up to Rs. 10 lakh); or
- When only one firm is qualified or has experience of exceptional worth for the assignment.

11. For **hiring of individuals**, it is necessary to finalize the job description, qualification and experience required and terms of the engagement. Thereafter, an advertisement (if the assignment is complex) may be put into the national/regional newspapers indicating the above details. The applications received

shall be scrutinized and ranking shall be prepared. Thereafter the top-ranked individual shall be invited for interview/discussions and would be offered the assignment.

3.5.3 Governance and accountability action plan

To implement the guiding principles of ensuring increased competition and transparency in procurement and in delivery of quality services, the RCH Phase II program will have better community oversight and procurement arrangements that ensure supply of quality goods and services, which are procured at a better price and delivered in a timely manner to end users.

3.6 Training

3.6.1 Training framework in RCH Phase II

Background

Availability of skilled human resources is critical to achieve goals of the RCH Phase II program. A set of technical and institutional strategies is detailed in the national and state PIPs to achieve these goals. Focus is on increasing access for a package of RCH services through variety of interventions. Delivery of these interventions will largely depend on human resources adequately equipped with knowledge, skills and motivation in different managerial and service delivery settings.

Hence the objectives of the National Training Strategy for RCH Phase II will be:

- To equip human resources engaged in the delivery of program interventions at different levels with requisite knowledge and skills
- To create an enabling environment for practice of these skills leading to improved performance.

Therefore, the strategy will include interventions not only to improve the clinical, managerial and communication skills of the health system personnel, but also creating an enabling environment for effective application of providers' skills resulting in improved service delivery at various service delivery points. As RCH Phase II is a comprehensive sector program, the training strategy will have to address the need for skill building among private providers also.

Elements of poposed training framework

The experiences of trainings conducted in RCH so far indicate that trainings are seen mostly as one-time activities to be conducted in the classroom setting with very limited emphasis on monitoring practice of newly acquired skills. There has been a varying degree of emphasis on identifying a set of critical skills required to perform specified tasks. There are also issues related to preparedness of institutions to conduct training, timely availability of training material and training aids and follow-up measures.

In order to improve the quality of training and also to make training lead to desired changes in the performance, strategy will have to focus on the following overarching elements.

- **Training inventory**

  As a first step, strategy should focus on identifying different categories of personnel at different levels of service delivery and program management who are likely to be engaged in RCH Phase II program delivery. State PIPs will provide necessary information on the categories of personnel and estimated numbers and key training objectives as per different technical and institutional strategies. Such an analysis will depict, in matrix form, key trainings to be organized for each category of personnel in the

health system. However there might be need for strengthening this section with inputs at the national level by the core group on training.

- **Training approach**

  One-time trainings are not panacea for improving performance. There could be different mechanisms for updating the knowledge of the providers and skills upgradation on a periodic basis. These approaches could range from utilization of IT based technologies to more conventional continuing education programs being organized by professional associations. In some states, satellite-based instructional programs are being conducted to reach out to a large number of providers through standardized software. It will be useful to fully utilize available experiences from the different states. Hence while no uniform training approach can be prescribed for the whole country, variations need to be recognized across the states and types of trainings.

- **Training contents**

  Trainings are to be organized in the framework of delivery of technical and institutional strategies. Contents and objectives of each training will be guided to a large extent by state PIPs. Each training will place emphasis on desired acquisition and retention of knowledge and skills by the health personnel and program managers.

  There is increasing recognition that due to the absence of social sensitivity issues e.g. rights, equity and gender; client-centric focus is lost. Thus, in RCH Phase II trainings there should be conscious efforts to integrate socially sensitive issues in the core trainings.

- **Monitoring of training**

  Ensuring quality of training is one of the important elements of the proposed training strategy. In the mid-term evaluation of RCH training, some concerns were raised about the quality of trainings being conducted for the peripheral functionaries at the district level.

  It is suggested that each training will have three phases in terms of design elements. The pre-training phase would include preparatory activities for conduct of trainings: identification of trainers, letters to the identified trainees, administrative approvals, availability of training material in adequate quantities and deciding venues for training, etc. Availability of appropriate checklists will help the training managers to assess readiness as per a defined work plan. Similarly, there is need to develop checklists to monitor training and post-training activities. States will have to set standards for monitoring training sessions and also insist on a post-training evaluation.

- **Training material development**

  Adaptation/ development of training material and ensuring availability in adequate quantities are crucial for effective training. Plenty of training modules, manuals, facilitator guides and training aids have been developed. Also many international agencies have access to the training material developed in specific projects supported by these agencies. It will be useful to have access to available training material, suggest alterations/ modifications/ additions/deletions in light of specific training objectives. Training sub-groups will review the available material for their respective program area and recommend adaptation if necessary. It is proposed that entire training material developed will be hosted on the departments' website.

- **Addressing enabling environment issues**

  As mentioned earlier, investments in training alone will not yield desired dividends in terms of improved program performance. Additional measures are needed so as to enable trainees to practice

skills. These measures could be in the form of infrastructure needs, equipment and supplies and availability of adequate staff to deliver services as per guidelines. Administrative sanctions will be issued for following these guidelines. It is envisaged that corresponding program interventions will address issues related to availability of supplies.

Sustained motivation of human resources is also critical. It is proposed to establish a system of rewards and recognitions for health personnel. Details of specific mechanisms will be worked out at the state level.

- **Training management**

  At the national level, facilitation needs for the organization of trainings in the states will be identified. These could be in terms of defining strategy for certain trainings, fulfilling the need for uniform training material and identification of national-level training institutions if necessary. As resources for the conduct of the trainings are reflected in the state PIPs, financial management in terms of sanctions and expenditures will be done in the states. It is also proposed to have a national level role for monitoring the quality of trainings on the sample basis. Similarly state program management structures will have focal points for training to monitor training plans and also to ensure plans for monitoring quality of trainings.

Operationalization of the training strategy

Training division in the DoH&FW will steer the operationalization and follow-up of this training strategy. A core group on training has been already constituted in the Department of Family Welfare. The core group will be responsible for finalizing the entire training strategy in RCH Phase II.

During the initial meetings of the core group, a work plan was finalized and seven sub-groups have been constituted to prepare the design notes for all generic trainings featuring in the RCH Phase II PIPs from the states. The design notes will guide further follow up actions.

Training institutions at national and state levels

Considering the range of trainings and projected training load in the states and districts, a wide range of training institutions in the states and districts will have to be relied upon. Admittedly there are inadequacies in the available training infrastructure in the states and districts. In the RCH program an attempt was also made to expand the existing pool of training institutions by inviting other agencies as CTIs. Experiences gained from such arrangements will be reviewed by the sub-groups being constituted to develop design notes on trainings. Accordingly new approaches need to be crafted for engaging agencies in the NGO and private sector to conduct trainings. Professional associations (i.e. IMA, IAP, and FOGSI) would be roped in to conduct training programs in the RCH Phase II. Similarly professional associations of nursing can be considered for organizing periodic continuing activities. NGOs with expertise and experience in organizing trainings of the grassroot functionaries on health-related issues might also be considered. It is proposed that the design documents of each sub-group will reflect the profile of training institutions to be engaged to conduct training and organize follow-up actions.

Conclusions

Achievement of RCH Phase II objectives is linked with timely delivery of training inputs and quality of training interventions. Human resources at different levels need be equipped with knowledge and skills to deliver services and manage programs in an effective manner. The proposed strategy reflects on different elements of a comprehensive approach and processes that need to be pursued leading to operationalization of strategy.

3.6.2 Proposed work plan for the core group constituted for RCH Phase II trainings

S.No.	Activities	Time Frame	Output	Responsibility
1.	Formulation of a training inventory in the RCH Phase II based on the state PIPs available so far	**Completed**	Comments on training in RCH Phase II including category of personnel to be trained and key areas of training	NIHFW
2.	Development of the TOR and general guidance note for the sub-groups on the basis of the training inventory	**Completed**	TORs and guidance note for each group developed, reflecting on the trainings to be considered for developing design notes	Core Group
3.	Constitution of the sub-groups on the following program areas: ■ Maternal Health ■ Child Health ■ Family Planning ■ Adolescent Health ■ Program Management ■ Induction of Support Management units ■ Training Management including PDC ■ Pre-service – Medical, and Nursing Education	**Completed**	Sub-group will develop design documents reflecting on the training objectives, contents of training, suggested training approach, availability of training material	Core Group
4.	Sub-groups meet to develop design documents for the different training reflected for each sub-group	**Completed**	Design documents for each training available, preferably 3-4 page documents	Sub groups. Each sub-group will have not more than 4-5 members and the program officer from the DFW will be convener. Interested DPs will be invited to join the sub-groups.
5.	Design documents to be analyzed for identifying state level implementation roles and to be shared with state governments	**Completed**	Notes for the state governments along with finalized design documents for different trainings. These notes will highlight specific roles of the states to roll out different trainings.	Core Group

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S.No.	Activities	Time Frame	Output	Responsibility
6.	Identification of the national level facilitation needs on the basis of the recommendations of the sub-groups	**Completed**	Document reflecting the national level facilitation needs and scheduling matrix developed	Core Group
7.	Development/adaptation of training material i.e., facilitators' guide, training aids and training material (complete training package)	30th June 2005	Training Material and design finalized Multiplication to be carried out at state level	NIHFW/Core Group
8.	Development of guidelines for the conduct of TOTs	31st July 2005	Document reflecting guidelines for conduct of different TOTs available	NIHFW/Core Group
9.	Training monitoring in states and districts	August 2005 onwards	Monitoring reports available with NIHFW to be shared in the review meetings with states	Core Group/NIHFW

3.7 Monitoring, Information and Evaluation Framework for RCH Phase II

3.7.1 Background

Monitoring and evaluation is an essential and integral part of the program development and implementation process. Monitoring is a routine process used to determine the extent to which the program has been effectively implemented at different levels, in time and at what cost. It is part of the management information system (MIS), and is basically an internal activity while evaluation is the application of research procedures to assess and improve ways in which policies and programs are conducted, from the earliest stages of defining and designing programs through their development and implementation. The results of evaluation exercises should inform program management, strategic planning, the design of new programs or initiatives, and the allocation of resources. It is therefore important for the M & E system to play multiple roles. These include measurement of performance on a regular basis at stipulated time intervals; identification of mid-course corrective actions needed to achieve program objectives; playing an advocacy role for the benefit of others working in the area; and help judicious allocation of resources.

The Monitoring and Evaluation sub-committee constituted by Government of India (GoI) believed *that the monitoring and evaluation system was not very effective and took a backseat during the first phase of RCH project. They were of the view that Community Needs Assessment Approach (CNAA) that formed the basis of service delivery planning was not implemented in its true spirit. Furthermore, multiplicity of registers compounded by complex reporting mechanism on variety of RCH indicators without much program relevance did not yield expected results and instead added to the burden of the field functionaries whose comprehension was poor. As a result, routinely and periodically collected information was rarely used for reviewing the program. The feedback mechanism, though an important component of monitoring and evaluation, was the major missing link. Hence, use of simple registers and*

reporting formats and monitoring/tracking indicators that evolve around program outputs and outcomes, that would provide insight and at the same time, proper direction to the program was recommended (M&E Working Group Report, 2004).

Context

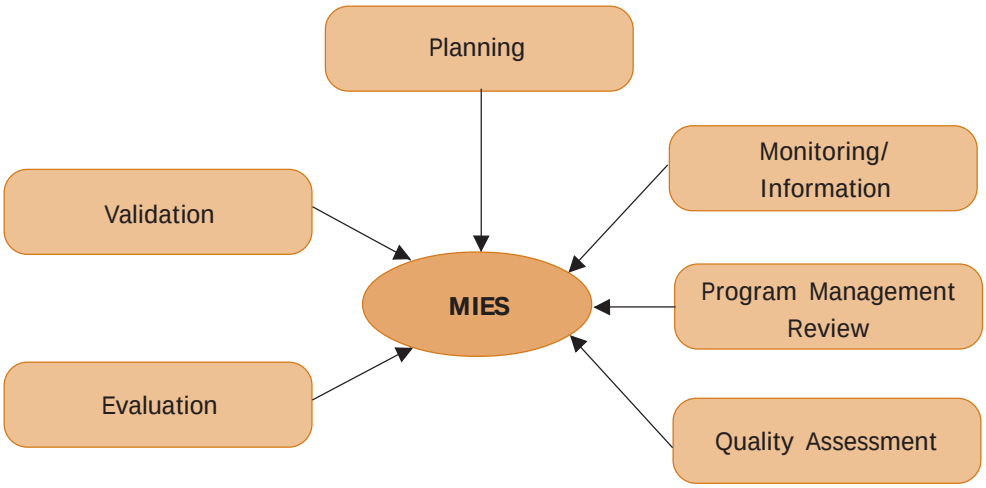
Realizing the importance of the suggestions of the sub-committee and the present environment of RCH Phase II, a need for streamlining of the M&E system was envisaged. An M&E group has been established. The group has been working on ways of approaching the M&E system in the context of RCH Phase II. The RCH Phase II program increasingly focuses on achieving output/outcome results. In line with the principles of RCH Phase II, most of the states have prepared their Program Implementation Plans (PIPs) and have also worked out in detail the logical framework analysis (LFA) wherein the output/outcome indicators have been spelt out along with the institutional/management arrangements and technical plan. Likewise, the district plans are to be evolved with district-specific objectives/goals and financial disbursements from GoI to state and state to districts are all linked to performance and achievement of the proposed objective/goal.

3.7.2 Approach to monitoring & evaluation

Premise

Figure 3.1 below gives an overview of the proposed MIES approach in RCH Phase II along with other presentations on CNAA, monthly reporting, triangulation of data and e-mode of transmission of data.

Figure 3.1



A systems approach would be adopted and would have various subsystems:

1. Planning
2. Monitoring/Information
3. Program Management Review
4. Quality Assessment

5. Evaluation

6. Validation (internal and external)

Each of the subsystems that would form major component of MIES at a later stage was deliberated. A summary of each of the subsystem is presented below:

1. Planning system

- Major responsibility of the state
- Implementation of State and district PIPs
- Service delivery estimation through CNAA
- Preparation of action plans at SC/PHC/district/state levels

2. Monitoring and information system

- Joint responsibility of the state and center
- CNAA cell has to be constituted at the state and district levels
- Cell should have an officer/demographer posted
- Cell may have a consultant or program assistant on contractual basis
- Transmission of data - e mode

3. Program management review (Piloting phase)

This initiative is going to be piloted by IIMA in the two states of Gujarat and Rajasthan to review/ evaluate management capacity at state and district levels on a sample basis

4. Assess quality of services (Piloting proposed to be initiated with INDIACLEN)

This initiative is also going to be piloted in 3 EAG states and 2 non EAG states to facilitate internal and independent monitoring of quality of services at the institutional level on a sample basis.

After the piloting phase has been completed, the M&E cell along with the agencies will work out a practical mechanism for institutionalizing the subsystem as part of the MIES. As INDIACLEN is a body comprised of medical college faculties, involvement of medical colleges in monitoring and evaluation of the quality of services can be explored. This would not only facilitate in creating in-house resources, but will also help in capacity building of program managers at the district level and below.

5. Evaluation system

The evaluation system will rely on different sources of information collected and compiled from various surveys. In the process, several independent and government funded agencies will be involved. The evaluation system will rely mainly on the following:

- District surveys (RHS and Facility) in 2007 and 2010
- NFHS III
- Focus studies
- Census/SRS Reports
- Formation of Regional Evaluation Teams
- Population Research Centers

6. Validation system

- Mechanism for ensuring quality of data
- Internal mechanism in the form of supervisory visits, consultations with PRIs
- External facilitation through surveys by government and other agencies
- Triangulation of data

Building on this exercise of the M&E Cell, an approach to MIES in RCH Phase II has been conceptualized.

The overall strategy of program monitoring and evaluation is to be linked to the participatory planning process, which the RCH Phase II envisages building on what was attempted in RCH Phase I. The MIES strategy henceforth should emphasize on results during project implementation and establish independent mechanisms to assess the quality of service provision, program management and impact evaluation.

In all, the entire MIES has been classified into three distinct areas - program inputs, monitoring and tracking and assessment review and evaluation. The first area on program input concerns the program implementation mechanism and includes the institutional and management arrangements and technical plans along with service delivery plans. Though this is spelt out in the PIP, the service delivery plan for program implementation has to be worked out. This will come from the CNAA in a revised format, which will have community level inputs in the form of qualitative analysis and survey of communities. In other words, service delivery estimates will emerge from the quantitative survey and area-specific requirements from the qualitative study. The new CNAA that is being planned would therefore enable service requirements along with area-specific needs. Hence, the CNAA will assume a new role and will be adopted after pre-testing. The CNAA and the PIPs together will henceforth form the program inputs and implementation mechanism.

The second area is on program tracking and monitoring. The verifiable indicators specified in the LFA and means of verification, the execution of activities as per the work-plan, coverage of physical and vulnerable groups and other indicators related to staffing, service quality, logistics, and financial management would have to be tracked and monitored continuously and periodically (continual basis, monthly, quarterly or biannually). This exercise is internal and would entirely rely on information systems and services being provided at the field level. In addition to this, to ensure proper management systems are in place, personnel trained and working, and quality services being provided have to be reviewed periodically. There is no doubt that these elements are crucial but how it is going to be facilitated internally, especially at district program level needs to be carefully examined and later elaborated upon. Electronic transmission of data from PHC level onwards will be introduced.

The third area will focus on the evaluation process. Evaluation of service quality, review of program management and assessment of impact will be undertaken. The evaluation mechanism will rely on baseline (CNAA, RHS reports at district level and other special studies), mid-term and end-line surveys. Findings of impact assessments would be complemented by studies on program management, quality of services and community reporting. The data so gathered will be validated by triangulation, which is being considered by the sub-committee. The triangulation of data would be done through surveys, management and quality review, service statistics and community feedback.

Approach for MIES in RCH Phase II

S.No.	Mechanism	Format	Periodicity	Responsible Agency / Persons	Purpose
Service delivery estimation					
1.	Baseline survey & PIPs	■ ECR/CNAA/ Service Registers ■ Census of all households	Beginning of each year and regular update	ANM	Establishing benchmark values
Monitoring and information					
2.	Information system ■ Continuous and periodic tracking	Redesigning of registers and reports (Simplification)	Continuous/ Monthly	M&E cell at district, state and national levels	Routine tracking of performance, quality of services
3.	Trip Reports	Check list for Performance, management and quality review	Monthly	Program Manager	■ Tracking of the above ■ Review, action taken and feedback Tracking and
4.	Rapid Assessment	Checklist for qualitative/ quantitative assessment	Half-yearly	Supervisory staff	corrections
Evaluation					
5.	■ Evaluation survey for indicators ■ Program management ■ Quality of services	Quantifiable data	■ Biannual ■ Annual (TBD) Once in two	M&E Cell (GoI and state)	■ Fund disbursement ■ Impact assessment and reconciliation
6.	Validation ■ Internal ■ External Triangulation of data	3 sets of data	years	M&E Cell (GoI, state and district)	■ Fund disbursement

3.7.3 M&E indicators in RCH Phase II

Since wide-ranging activities have been proposed in the RCH Phase II program, it has been agreed that few critical indicators would be given priority attention for releasing funds, assessing the program impact on use of RCH services and determining the eligibility for the performance bonus (Generic MoU placed as an Annex). GoI will sign the Memorandum of Understanding (MoU) with the state governments on the benchmarks to be achieved. It also plans to provide additional funds to states that perform better than the agreed benchmarks.

Three sets of program indicators related to institutional processes, outputs and performance bonus have been suggested. Given that there are going to be three sets of indicators related to institutional, output and performance bonus for monitoring and evaluation, the M&E mechanism has to be devised in such a manner so as track the process indicators on a regular basis.

Furthermore, the indicators have to be disaggregated, taking into account equity and gender elements and have to be succinctly captured through the information system and evaluations have to be clearly defined. In other words, the mode of data collection has to be spelt out first. Later, the frequency of reporting of these indicators has to be explicitly stated for appropriate and timely corrective measures and actions.

3.7.4 Roadmap for monitoring, information and evaluation systems

S.No.	Action Point / Activities	Proposed to be completed by
	MIS	
1.	Preparation of performance reporting formats in consultation with the UNFPA, NIC, state / district of officials other stakeholders etc.	15th April 2005
2.	Capacity building-assessing and providing the required infrastructure, manpower in consultation with all stakeholders, preparation of IT plan of action in consultation with NIC	30th June 2005
3.	Development of the software by NIC	31st August 2005
4.	Pilot in states (2 EAG and 1 non EAG) 4 districts each (pre-testing of formats/software)	October/November 2005
5.	Finalization of formats, software, etc. based on the experience of pre-testing	December 2005
6.	Implementation of computerized MIS	January 2006
	CNA(M)A	
1.	Preparation of revised CNAA manual/guidelines	July 2005

S.No.	Activity	Responsibility	To be completed by
	District Household Surveys 2006-07		
1.	Constitution of a technical advisory committee for planning and supervision of the district RCH and facility surveys	Ministry of Health & Family Welfare	December, 2004
2.	Deciding nodal agency for RCH-II district Surveys to be conducted in 2006-07 and 2009-2010	Ministry of Health & Family Welfare	June, 2005
3.	Terms of Reference of the nodal agency	Ministry of Health & Family Welfare	June, 2005
4.	Meeting of Technical Advisory Committee to discuss sampling design and questionnaires of RCH-II district surveys/facility surveys 1st meeting 2nd meeting for finalizing schedules and sampling design Pilot testing of questionnaires	 IIPS IIPS	 January, 2005 July, 2005
5.	Finalize survey questionnaires based on the Pilot test in	IIPS	October, 2005
6.	a meeting of TAC Finalize manual for field states	IIPS	September, 2005
7.	To prepare tabulation plan and format for the district	IIPS	September, 2005
8.	RCH surveys and place before TAC To finalize the tabulation plan and format for the	IIPS	November, 2005
9.	district RCH surveys Develop user-friendly software (data entry, tabulation	IIPS/ Ministry of Health & Family Welfare	November, 2005
10.	plan) Constitution of a Committee for seeing the work	IIPS	November, 2005
11.	of survey organization including state representatives. Letter for expression of interest to survey	IIPS/Min. of Health & Family Welfare	June, 2005
12.	organizations and TORs of the survey organization Briefing to the survey agencies	IIPS/Min. of Health & Family Welfare	December, 2005
13.	Receipt of technical and financial proposals for	IIPS	December, 2005
14.	conducting surveys Evaluation of technical and financial proposals of the	IIPS	February, 2006
15.	RCH surveys Deciding the organizations for survey	IIPS/Committee	April, 2006
16.	Training of trainers of survey organizations	IIPS/Committee	June, 2006
17.	Training of field staff by survey organizations	IIPS	November, 2006
18.	Start of field work		January, 2007
19.			March-July 2007

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S.No.	Activity	Responsibility	To be completed by
	District Household Surveys 2006-07		
20.	Data entry and validation of data	IIPS	Survey reports to be available by December 2007. National Seminar to be organized in February 2008.
21.	Preparation of draft district reports	IIPS	
22.	Finalization of district reports	IIPS	
23.	Preparation of states and national report	IIPS	
24.	National seminar for dissemination of results	IIPS	
25.	National seminar for dissemination of the survey results	IIPS	

S.No.	Action Point	Proposed to be completed by
	Evaluation of quality of Reproductive & Child Health services	
1.	Finalization of draft proposal for Quality Assesment	July, 2005
2.	Consultation with development partners and program officers.	September, 2005
3.	Preparation of formats, tools, questionnaire, in consultation with all stakeholders, including consultation a few state directors/district officials.	August, 2005
4.	Pilot in two states (one EAG and one non-EAG) one district each; report writing.	October, 2005
5.	Finalization of formats, developing strategies, consultation with stake holders, state authorities, etc.	October/November, 2005
6.	Establishment of nodal points; workshop with nodal points of the state nodes, quality asssesment agency	November, 2005
7.	Operationalization of the first phase-3 EAG and 2 non-EAG	Feburay, 2006
	Management Evaluation Assessment of institutional arrangement – to be undertaken by nodal institution for management review	
1.	Review of literature, detailing of methodology, discussion with stakeholders.	August, 2005
2.	Development of tools, formats, questionnaire, management indicators.	August, 2005
3.	Visit to two states-(Gujarat and Rajasthan), collection of data, analysis, study of institutional process, program planning, implementation, quality assurance, logistics, HRM & FM etc.-PILOT	October, 2005
4.	Report preparation, its finalization, meeting with stakeholders including state/district officials.	December, 2005
5.	Operationalization of first phase-3 EAG and 2 non-EAG states	December, 2005-January, 2006

Logical Framework Approach (LFA)

Program title : RCH Phase II
Planned program period : 01.04.2005 – 31.03.2010
Prepared on : 31.3.2005

Department of Family Welfare
Government of India

Outputs/Outcomes	Objectively Verifiable Indicators (OVI)	Means/Source of Verification (MOV)
Overall goal: [Superior strategic goal for the project] The Reproductive and Child/Newborn Health Status in India is improved	(Major characteristics of the results) By 2010, as envisaged in the National Population Policy: TFR reduced to 2.1 Maternal mortality ratio reduced to 100/100000 live births Infant mortality rate reduced to less than 30/1000 live births, especially among the poorest	(Where to find the evidence/information) Census Registrar General of India National Surveys
Program purpose: [Change in actions of the users of the project's services] Communities utilize and benefit from responsive, equity-sensitive and quality- based Reproductive and Child/Newborn Health Care services To enhance performance particularly, family planning mission approach would be adopted, to provide support in respect of design and monitoring of projects and programmes for family planning and related IEC campaign	**Family Planning** Improved 'couple protection rate' with enhanced share of spacing methods ▪ Overall ▪ BPL/SC/ST ▪ EAG & NE states Reduced unmet need for spacing methods among eligible couples: ▪ Overall ▪ BPL/SC/ST ▪ EAG & NE states Increased availability & quality of sterilisation services in public and private sectors. Increased male participation in responsible parenthood.	Reports from States Survey

Logical Framework Approach (LFA)

Program title : RCH Phase II
Planned Program period : 01.04.2005 – 31.03.2010
Prepared on : 31.3.2005

Department of Family Welfare
Government of India

Outputs/Outcomes	Objectively Verifiable Indicators (OVI)	Means/Source of Verification (MOV)
	Improved use of NSV by promoting positive attitude among users and demand side financing. Increase in skilled / trained professional providers from the public / private / corporate sector providing family planning services.	Reports from States Survey
	Maternal Health and RTIs/STIs Increase in the proportion of deliveries by skilled birth attendants (doctors, nurses, ANMS) ■ Overall ■ BPL/SC/ST ■ EAG & NE states Increase in the proportion of all births in government and private institutions ■ Overall ■ BPL/SC/ST ■ EAG & NE states Increase in the proportion of BPL pregnant women receiving 3 or more antenatal checks, 2 doses of tetanus toxoid injections and 100 tablets of IFA : ■ Overall ■ EAG & NE states Reduction in proportion of complicated abortions	Reports from States Survey

Logical Framework Approach (LFA)

Program title : RCH Phase II
Planned program period : 01.04.2005 – 31.03.2010
Prepared on : 31.3.2005

Department of Family Welfare
Government of India

Outputs/Outcomes	Objectively Verifiable Indicators (OVI)	Means/Source of Verification (MOV)
	▪ Overall ▪ BPL/SC/ST ▪ EAG & NE states Increase in the proportion of women with RTI/STI seeking advice and treatment from public/private providers and institutions. ▪ Overall ▪ BPL/SC/ST ▪ EAG & NE states Improved privacy for adolescents and women receiving FP/MTP/RTI/STI services as perceived by clients	Surveys
	Child Health/Neonatal Health Increase in the proportion of neonates (and mothers) receiving 3 visits by a provider (ANM/AWW/Link volunteer/ASHA) within the first week of birth (with one visit within 24 hours at home or after discharge from the facility for institutional deliveries). ▪ Overall ▪ BPL/SC/ST ▪ EAG & NE states	DWCD and health department reports from States Surveys

Logical Framework Approach (LFA)

Program title : RCH Phase II
Planned Program period : 01.04.2005 – 31.03.2010
Prepared on : 31.3.2005

Department of Family Welfare
Government of India

Outputs/Outcomes	Objectively Verifiable Indicators (OVI)	Means/Source of Verification (MOV)
	Increase in the proportion of neonates who were breastfed on day 1 of life and exclusively at 6 months of age ■ Overall ■ BPL/SC/ST ■ EAG & NE states	Surveys
	Increase in the proportion of infants who were receiving complementary feeds apart from breastfeeding at 9 months of age ■ Overall ■ BPL/SC/ST ■ EAG & NE States	Surveys
	Increase in the proportion of neonates and children with following illnesses in the previous 4 weeks who receive appropriate medication (viz. ORS, antibiotic) as per IMNCI protocols ■ Diarrhea ■ Acute respiratory infections ■ Neonatal sepsis	Surveys
	BPL/SC/ST neonates and children who made use of private sector care through voucher system, insurance or any other agreed mechanism.	Surveys

Logical Framework Approach (LFA)

Program title : RCH Phase II
Planned program period : 01.04.2005 – 31.03.2010
Prepared on : 31.3.2005

Department of Family Welfare
Government of India

Outputs/Outcomes	Objectively Verifiable Indicators (OVI)	Means/Source of Verification (MOV)
	Zero polio status maintained. Reduction in the incidence of vaccine preventable diseases ■ Utilization rate (BPL/ SC/ST) ■ Client satisfaction (BPL) Strengthened intra-sectoral convergence within the MoH&FW and inter-sectoral convergence with NACP and WCD	Certification by WHO Surveys Integrated set up in the MoH&FW Evidence of institutionalisation of convergence and networking among systems

Logical Framework Approach (LFA)

Program title : RCH Phase II
Planned Program period : 01.04.2005 – 31.03.2010
Prepared on : 31.3.2005

Department of Family Welfare
Government of India

Outputs/Outcomes	Objectively Verifiable Indicators (OVI)	Means/Source of Verification (MOV)
Output/Objective: [Products and services generated by the project management] **1. The management structure of the existing health system is effectively decentralized, capacity is strengthened at all levels (actively involving PRIs, NGOs and the private sector) and with effective intra- and inter-sectoral convergence.**	[Major characteristics of the results] All States have State plans based on district/ municipal plans for at least 50% districts (with a focus on the lowest performing districts in terms of TFR, MMR, IMR) by the end of FY 2007: MoU that conforms to RCH Phase II principles and log frame signed with center by all States by FY 05-06. Improved efficiency in the use of financial resources Audit reports submitted within 6 months of closure of financial year Institutionalization of convergence issues at central and State levels with NACP and WCD	State Plans MoU Financial and performance reports Audit Reports Government order

Logical Framework Approach (LFA)

Program title : RCH Phase II
Planned program period : 01.04.2005 – 31.03.2010
Prepared on : 31.3.2005

Department of Family Welfare
Government of India

Activities	Objectively Verifiable Indicators (OVI)	Means/Source of Verification (MOV)
Main Activities to achieve Output 1		
1.1. Strengthen the decentralized planning process		
Provide guidelines and manual outlining the planning process to the States and districts	Guidelines and manual outlining planning process circulated to States after expert group review of State and district plans.	All States confirm receipt and use for planning
Build capacity of the EAG States to carry out the planning	Training provided to EAG States in the use of the planning manuals and process of planning.	Number of trainings conducted and training report
1.2. Prioritize RCH interventions based on local needs and develop a system for assessing performance	State and district plans and log frames.	Plans appraised for resource allocation and for development of MoUs
1.3. Draw up MoU with the States based on agreed indicators of performance	MoU that conforms to RCH Phase II principles signed with center by all States by end FY 2005-2006.	Signed MoUs
	Minimum standards for each type of services established.	Standards document developed and disseminated
	Systems to monitor adherence in place.	Systems document Disaggregated reports State annual reports and review minutes

Logical Framework Approach (LFA)

Program title : RCH Phase II
Planned Program period : 01.04.2005 – 31.03.2010
Prepared on : 31.3.2005

Department of Family Welfare
Government of India

Activities	Objectively Verifiable Indicators (OVI)	Means/Source of Verification (MOV)
Main Activities to achieve Output 1		
1.4. Strengthen the program management support structure		
Accomplish **organizational review** of DoH&FW and implement recommendations	Agreements on reorganization by March 2005.	GoI's orders for reorgnization and implementation
For one-year institutional development Phase, provide interim funding & management mechanisms	Criteria for institutional preparedness	Reports on preparedness and fund flows
Develop mechanisms for coordination of technical assistance from Development Partners	National Health Systems Resource Center (NHSRC)	NHSRC established
Define parameters of State level institutional preparedness	Criteria for State preparedness	State PIPs and Log Frames
Develop modalities for use of flexible funding	Modalities for use of flexible funding established	Finance and Accounting Manual
Develop social and environmental safeguard policies and share with States	Environmental and social safeguard policies developed and disseminated	Policy document dissemination report.
Guidelines developed for expanding institutional capacities for health through social marketing programs	Guidelines	Guidelines document
Develop market oriented behavior change communication strategy	Strategy identifying visibility quality products and effective distribution mechanism.	Strategy document

Logical Framework Approach (LFA)

Program title : RCH Phase II
Planned program period : 01.04.2005 – 31.03.2010
Prepared on : 31.3.2005

Department of Family Welfare
Government of India

Activities	Objectively Verifiable Indicators (OVI)	Means/Source of Verification (MOV)
Develop policy for convergence with ICDS/ DWCD / NACP	Policy decision taken by end 2004	Policy document
	Convergence groups formed in all States by July 2005	Report
	Job responsibilities of ANMs and AWWs defined and disseminated consequent upon such convergence	Job chart
	Technical group on RCH-NACP formed	Reports
Improve linkages between primary/secondary and tertiary care institutions by:		
■ Creating networking systems to ensure smooth, rapid and client centered referral	Networking system to ensure smooth, rapid and client centered referrals incorporated in the State PIPs/LFs	State PIPs/LFs
■ Forming a coordination committee at State level representing teaching institutions, State health system corporations, private sector, municipalities etc. apart from FW department	Coordination committees formed	Order forming the committees Minutes of quarterly meetings

Logical Framework Approach (LFA)

Program title : RCH Phase II
Planned Program period : 01.04.2005 – 31.03.2010
Prepared on : 31.3.2005

Department of Family Welfare
Government of India

Activities	Objectively Verifiable Indicators (OVI)	Means/Source of Verification (MOV)
1.5. Improve the Financial Management systems at center, State and district levels		
1.6. Key financial personnel in place at center and States	Staff in position	Appointment orders
Strengthen financial management systems and structures	Financial management structures reorganized	GO for reorganization and report on reorganization
Develop and disseminate "Finance and Accounting Manual" containing revised set of accounting procedures and policies for all levels.	Manual developed and disseminated	Dissemination Report on the Manual
Improved efficiency in use of financial resources	Percentage of plans not delivered due to late or insufficient funds is: ■ < 50% in both EAG and non-EAG States by end 2005 ■ < 30% in both EAG and non-EAG States by end 2006	Report on variance between estimated date of fund release and actual date.
Undertake *financial management performance evaluation* of States based on agreed criteria and methodology	Quarterly/annual *Financial Monitoring Reports* linking physical achievements with expenditure available in: ■ 50% of both EAG & non EAG States by FY 2006 ■ All States by FY 2007	Financial and performance monitoring reports
Ensure streamlined system of funds-flow (center to State)	Audit reports of acceptable quality submitted within 6 months of FY closure.	Audit reports
Financial reports form basis for decision making	Reports on actual expenditure is at least 50% of the releases required before the release of the next tranche	Concurrent review reports of physical and financial performance

Logical Framework Approach (LFA)

Program title : RCH Phase II
Planned program period : 01.04.2005 – 31.03.2010
Prepared on : 31.3.2005

Department of Family Welfare
Government of India

Activities	Objectively Verifiable Indicators (OVI)	Means/Source of Verification (MOV)
1.7. Strengthen infrastructure for more effective program		
Undertake infrastructural strengthening of SCs/ PHCs/CHCs/FRUs and medical colleges as per PIP	Number of SCs/PHCs/CHCs/FRUs and medical colleges conforming to infrastructural norms	Facility survey
1.8. Facilitate positive RCH outcomes by establishing sound procurement & logistics systems		
Setting up of national procurement and logistics management authority	Procurement and logistics management division established	Government order establishing the division and defining its scope and functions
Define norms for drugs/disposable/other supplies/functional equipment that must be in place at different levels of health system and AWWs on all days of year	Norms and the line of responsibility	Document
Develop Action Plan for procurement, logistics, supplies	Action plan for procurement, logistics, supplies developed by March 2005	Action Plan document
Document the experience of Tamil Nadu Medical Supplies Corporation and disseminate it to other States	Tamil Nadu experience documented	Tamil Nadu Medical Supplies Corporation document and dissemination reports
Develop procurement planning and procurement systems	Planning and procurement systems available	Procurement Plans 90% of CHC &PHC report supplies received on time by end FY 2005; Reported drug loss due to time expiry reduced to 5% of stock turnover

Logical Framework Approach (LFA)

Program title : RCH Phase II
Planned Program period : 01.04.2005 – 31.03.2010
Prepared on : 31.3.2005

Department of Family Welfare
Government of India

Activities	Objectively Verifiable Indicators (OVI)	Means/Source of Verification (MOV)
Provide technical assistance and support for training and monitoring at State levels	Technical assistance requirements assessed and plan for technical assistance evolved	Technical assistance assessment report and TA plan document.
Develop training curricula and modules for procurement and logistics	Training modules available based on training curricula developed	Training module documents
Guidelines for Public-Private Partnership in distribution logistics developed	Guidelines document available for PPP in distribution logistics	Guideline document

Logical Framework Approach (LFA)

Program title : RCH Phase II
Planned program period : 01.04.2005 – 31.03.2010
Prepared on : 31.3.2005

Department of Family Welfare
Government of India

Outputs/Outcomes	Objectively Verifiable Indicators (OVI)	Means/Source of Verification (MOV)
2. Suitably trained, motivated and responsive staff are in place in appropriate facilities	70% staff have undertaken in-service update training by FY 2007	Training reports from training institutions

Logical Framework Approach (LFA)

Program title : RCH Phase II
Planned Program period : 01.04.2005 – 31.03.2010
Prepared on : 31.3.2005

Department of Family Welfare
Government of India

Outputs/Outcomes	Objectively Verifiable Indicators (OVI)	Means/Source of Verification (MOV)
Activities		
2.1 Develop and implement an action plan of training for all providers with special emphasis on enhancing skills.		
Review existing training program, assess training needs for RCH Phase II, identify organizational bottlenecks and capacity gaps	Reviews done	Review report
Develop training strategy and training plans for training of providers/managers with emphasis on skills enhancement	Training plans developed by June 2005	Training strategy and plans
Roles of NIHFW defined and made operational	Role defined by June 2005	Memorandum of Understanding
2.2 Operationalize RCH Link Volunteer Initiative as per State PIPs		
Develop curriculum and training modules	Curriculum and training modules developed by June 2005	Training material
Training of 100,000 volunteers in 10 States (8 EAG States, Assam and J&K) by December 2006 as per phasing plans	Evaluation of training and performance	Evaluation reports
Scaling up initiatives to remaining districts in the EAG States	Evaluation of training and performance	Evaluation reports

NB: The training and deployment of the new cadre of village level workers, ASHA will be carried out as per the National Rural Health Mission plans.

Logical Framework Approach (LFA)

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Department of Family Welfare
Government of India

Outputs/Outcomes	Objectively Verifiable Indicators (OVI)	Means/Source of Verification (MOV)
3. Monitoring and evaluation systems based on transparent data collection and analysis focusing on identifying the barriers to equitable RCH outcomes introduced and functioning	Develop common MIES by January 2006 Designated institution(s) State identified and contracted by January 2006 in each State for assessment, collation & analysis of data Disaggregated analysis of district household survey (2002-03) baseline data by SC/ST/ BPL & gender available by 2005 from 50% of states Computerized MIES available for use in the public health system by end 2005	GoI guidelines Contracts with institutions Disaggregated reports MIES system

Logical Framework Approach (LFA)

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Department of Family Welfare
Government of India

Activities	Objectively Verifiable Indicators (OVI)	Means/Source of Verification (MOV)
Main Activities to achieve Output 3		
3.1 Improve district level household surveys to reflect equity and access issues	Areas for improvement identified for household surveys and actions initiated	Action initiated report
3.2 Develop guidelines for using local data to prepare and monitor plans	Guidelines for use of MIES data at local levels developed	Guideline document
3.3 Networking of MoH&FW GoI, ICMR & affiliated institutions, PRCs, NIHFW, FW training centers, IIPS, SIHFWs etc. for cost effective and user friendly access to, and sharing of, information/data generated and outcomes of research efforts along with associated communication systems (incl. video conferencing and hardware supports wherever necessary)	Availability of networked electronic multimedia communication system (audio, video, & text) supporting financial personnel, material, marketing and sales monitoring & evaluation of clients' sensitive management systems.	Networking reports
	Availability of information on website	Website
3.4 Develop equity indicators into large national surveys such as NFHS in order to include program components to address these	Indicators to assess equity and access developed and data needs identified	Indicators list and data needs
3.5 CNAA manual to be revised with field test in one EAG and one non EAG State	Revised CNAA manual developed by July 2005	Revised CNAA manual

Logical Framework Approach (LFA)

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Planned program period : 01.04.2005 – 31.03.2010
Prepared on : 31.3.2005

Department of Family Welfare
Government of India

Activities	Objectively Verifiable Indicators (OVI)	Means/Source of Verification (MOV)
3.6 Develop a simplified and uniform pro-forma for MIES	Uniform pro-forma for MIES developed	MIES pro-forma
3.7 Develop softwares for generating quarterly analytical reports and annual reports	Software developed	Software
3.8 Provide all districts with computers and required software and training	Availability of support infrastructure	Required computers and software available
3.9 Concurrent evaluation studies and special service using a common design and reporting format. IIPS, SIHFWs etc., for cost effective and user friendly access to and sharing of information	Evaluation conducted	Evaluation study reports
3.10 Quality assurance surveys	Operationalized in 3 EAG and 2 non EAG states by January 2006	Reports
3.11 Program management reviews	Operationalized in 3 EAG and 2 non EAG states by January 2006	Reports

Logical Framework Approach (LFA)

Program title : RCH Phase II
Planned Program period : 01.04.2005 – 31.03.2010
Prepared on : 31.3.2005

Department of Family Welfare
Government of India

Outputs/Outcomes	Objectively Verifiable Indicators (OVI)	Means/Source of Verification (MOV)
4. Women, men and adolescents are enabled to access gender-sensitive family planning services and contribute to the population stabilization policies of the GoI using measures of their own choice with focus on 150 high fertility districts.	Proportion of sampled villages in a State having at least one CBD (Community based distribution) outlet Proportion of PHCs providing Cu 380 & EC round the year Proportion of public providers competent in providing spacing methods Number of social marketing units operating in States Number of providers included in social franchising program in a State Proportion of contribution of social marketing to total spacing method use Proportion of couples knowing benefits of spacing and aware where services are available. Increased male participation in responsible parenthood Improved visibility on population stabilization agenda	Reports from states' surveys

Logical Framework Approach (LFA)

Program title : RCH Phase II
Planned program period : 01.04.2005 – 31.03.2010
Prepared on : 31.3.2005

Department of Family Welfare
Government of India

Activities	Objectively Verifiable Indicators (OVI)	Means/Source of Verification (MOV)
Main Activities to Achieve Output 4		
4.1 Establishment of centres of excellence (COE) for family planning services		
Reduce the *'unmet need'* for spacing		
Establish standards and guidelines for ■ Social Marketing ■ Social Franchising ■ Community based distribution (CBD) of contraceptives	Respective policy and guidelines developed and disseminated by June 2005. Policy decision taken and implemented	Guideline documents
Reorganized and strengthened social marketing (SM) units perform new roles and responsibilities	SM unit reorganized	Organization structure Reorganization order
■ Quality standards for family planning services		Policy document
■ Increased involvement of private sector and corporate sector in the delivery of FP service	Knowledge / awareness and skill of expanded range of contraceptives amongst medical officers in districts.	Reports
Expand the range of contraceptives and ensure availability at district and sub-district levels		
■ Increased male participation	Counselling and male oriented BCC package	Quarterly review meeting by States and annual meeting by center
■ Focus on newly married couples	BCC package for newly married couples	Delay in first child /space between first and second child

Logical Framework Approach (LFA)

Program title : RCH Phase II
Planned Program period : 01.04.2005 – 31.03.2010
Prepared on : 31.3.2005

Department of Family Welfare
Government of India

Activities	Objectively Verifiable Indicators (OVI)	Means/Source of Verification (MOV)
Reduce the unmet need for terminal methods of family planning ■ Put quality assurance teams in place ■ CHCs/FRUs/district hospitals providing permanent FP services for men and women all round the year ■ PHCs offer permanent FP services at least once every month ■ Private practitioners and corporate sector hospitals/ clinics are accredited to offer FP services Protocols for accreditation of private and corporate sector for family planning services ■ Provide better parity and promotion for Non Scalpel Vasectomy as policy	By 2007 All major states have quality assurance teams in place 100% CHCs/FRUs/district hospitals provide permanent male and female FP services round the year. 50% of PHCs offer permanent FP services at least once every month. 50% increase in number of private practitioners accredited to offer FP services. Increase in proportion of Non Scalpel Vasectomies	Reports from State surveys Reports from corporate sector

Logical Framework Approach (LFA)

Program title : RCH Phase II
Planned program period : 01.04.2005 – 31.03.2010
Prepared on : 31.3.2005

Department of Family Welfare
Government of India

Activities	Objectively Verifiable Indicators (OVI)	Means/Source of Verification (MOV)
Professional indemnity insurance for failure in permanent family planning methods	Number of doctors / professionals benefiting under the scheme by end 2005.	State report
Design and develop a communication strategy to meet the requirement.	Communication strategy document available at the national level by June 2005	Communication strategy document
Plan communication campaign through different media using multiple approaches.	Media plan developed and available for implementation by October 2005	Media Plan, Media Campaign Reports
Revision of rates for compensation to acceptors of sterilization.	Revised rates developed and adopted	Quantum of compensation disbursed
National commitment campaign to raise awareness on small family norms and girl child.	Number of couples accepting sterilization	
Strengthening contraceptive logistics and marketing management and diversification through an identified agency.	Order issued appointing the agency	Order of appointment
Social marketing of family planning process in addition to the products and social franchising of injectables starting with urban areas.	Marketing management and diversification strategy developed by the agency improved availability of contraceptives reported from different geographic areas	Market assessment report by an independent agency
Strengthening social marketing of condoms through condom vending machines.	Number of condom vending machines dispensing condoms	Social marketing sales reports

Logical Framework Approach (LFA)

Program title : RCH Phase II
Planned Program period : 01.04.2005 – 31.03.2010
Prepared on : 31.3.2005

Department of Family Welfare
Government of India

Outputs/Outcomes	Objectively Verifiable Indicators (OVI)	Means/Source of Verification (MOV)
5. Gender sensitive, quality maternal health services, including for RTIs/STDs are available and accessible, especially for the poor	Proportion of deliveries by skilled birth attendants (*Doctors, nurses, ANMs*) ■ Overall ■ BPL/SC/ST ■ EAG & NE states Proportion of all births in government and private institutions ■ Overall ■ BPL/SC/ST ■ EAG & NE states Proportion of BPL pregnant women getting registered in first trimester; and receiving 3 or more antenatal checks, 2 doses of tetanus toxoid injections and 100 tablets of IFA: ■ Overall ■ EAG & NE states Proportion of women receiving post-partum care in the first week after delivery; ■ Overall ■ BPL/ SC/ST ■ EAG & NE states	State reports Surveys

Logical Framework Approach (LFA)

Program title : RCH Phase II
Planned program period : 01.04.2005 – 31.03.2010
Prepared on : 31.3.2005

Department of Family Welfare
Government of India

Outputs/Outcomes	Objectively Verifiable Indicators (OVI)	Means/Source of Verification (MOV)
	Proportion of women with RTI/STI seeking advice and treatment from public/private providers and institutions. ▪ Overall ▪ BPL/SC/ST ▪ EAG & NE states	State reports Surveys
	Proportion of adolescents and women satisfied with privacy standards while availing of FP/MTP/RTI/STI care at government facilities (PHCs/CHCs/FRUs/district hospitals)	Exit interviews
	Proportion of abortions estimated to be complicated	Surveys

Logical Framework Approach (LFA)

Program title : RCH Phase II
Planned Program period : 01.04.2005 – 31.03.2010
Prepared on : 31.3.2005

Department of Family Welfare
Government of India

Activities	Objectively Verifiable Indicators (OVI)	Means/Source of Verification (MOV)
Main Activities to achieve output 5 **5.1 Improved use of skilled care for delivery and early neonatal care** Develop policies and guidelines including involvement of private sector by March 2005 for ■ Increasing deliveries conducted by skilled attendants and improving access to EmOC services ■ Improving use of safe delivery services especially by the poor/SC/ST women through Janani Suraksha Yojana, other innovative demand side financing and BCC strategies ■ Enhancing access to referral transport and use of designated funds	Policies and guidelines for these three areas in place by March 2005	Policy and guidelines documents
5.2 Increased access to emergency obstetric care with focus on the poorest <u>PHCs and CHCs</u> Develop guidelines, norms, criteria of operationalization and procedure for certification for providing 24 hour delivery as well as newborn and child care services at PHCs and CHCs.	Guidelines, norms, criteria of operationalization and procedure for certification developed and disseminated by March 2005	Document
Operationalize at least 50% PHCs and 100% CHCs to provide 24 hour delivery and newborn care services according to GoI norms by 2009.	Proportion of specified facilities operationalized as per GoI norms ■ Overall ■ EAG & NE states	Reports from States Reports from central teams' Surveys

Logical Framework Approach (LFA)

Program title : RCH Phase II
Planned program period : 01.04.2005 – 31.03.2010
Prepared on : 31.3.2005

Department of Family Welfare
Government of India

Activities	Objectively Verifiable Indicators (OVI)	Means/Source of Verification (MOV)
5.3 FRUs		
Develop guidelines, norms, criteria of operationalization and procedure for certification for Emergency Obstetric Care (including provision of Caesarean section and blood storage/banking facilities) and newborn/child care services at FRUs by March 2005.	Guidelines, norms, criteria of operationalization and procedure for certification developed and disseminated by March 2005.	Document
Operationalize at least 2000 First Referral Units in a phased manner starting with district hospitals for providing emergency obstetric care (including provision of Caesarean section and blood storage/banking facilities) and newborn/child care services according to GoI norms by 2008 2005 200 2006 Additional 400 2007 Additional 600 2008 Additional 800	Number of FRUs operationalized in a sustained manner per GoI norms	Reports from States Reports from central teams Surveys
5.4 Improved access to quality antenatal services especially among the poorest		
Develop quality standards, guidelines and indicators for quality antenatal services in community and facilities.	Quality norms, guidelines and indicators developed and disseminated by April 2005	Reports from States Surveys
Enhanced quality of ANC in community and at facilities.	Quality indicators of antenatal care per above	
Fixed day ANC clinics by ANMs at each Anganwadi; make special efforts to reach the poor, the adolescents and the marginalized by effective outreach activities and community mobilization.	Proportion of planned ANC clinics held. Proportion of eligible BPL/SC/ST cases covered	

Logical Framework Approach (LFA)

Program title : RCH Phase II
Planned Program period : 01.04.2005 – 31.03.2010
Prepared on : 31.3.2005

Department of Family Welfare
Government of India

Activities	Objectively Verifiable Indicators (OVI)	Means/Source of Verification (MOV)
5.5 Improved access to post-partum care Develop algorithm and management guidelines for post-partum care for expanded version of IMNCI. Post-partum contacts by Anganwadi workers/ANMs according to a recommended schedule for care of the mother and the baby using expanded IMNCI approach.	IMNCI expanded to include post-partum care for the mother by July 2005 Proportion of post-partum women receiving visits from AWW/ ANM/link volunteer	Modified IMNCI chartbook and training module (For AWW, ANMs / LHVs and physicians) AWW/ANM reports Surveys
5.6 Reduce unsafe abortions. Provide quality MVA (manual vacuum aspiration) services at 50% PHCs and comprehensive MTP services at all CHCs, all FRUs, and all district hospitals by 2009	Norms for MTP services at different level of facilities developed by March 2005 (in conjunction with those for EmOC referred to above) Proportion of PHCs, CHCs, FRUs and distrct hospitals providing MTP services as per norms	Norms and guidelines Reports from States Surveys

Logical Framework Approach (LFA)

Program title : RCH Phase II
Planned program period : 01.04.2005 – 31.03.2010
Prepared on : 31.3.2005

Department of Family Welfare
Government of India

Activities	Objectively Verifiable Indicators (OVI)	Means/Source of Verification (MOV)
5.7 Improve access to quality and women friendly & responsive RTI and STI services. Develop guidelines for ANMs for providing counseling and simple treatment of RTIs/STIs in government and private sectors. Operationalize diagnostic and treatment services at 50% PHCs, all CHCs and all FRUs by 2009.	Guidelines developed by March 2005 Norms for STI/RTI services at different level of facilities developed by March 2005 (in conjunction with those for EmOC referred to above) Proportion of facilities made functional in providing diagnostic and treatment services as per norms.	Guidelines Norms and guidelines Reports from States Surveys
5.8 Enable ANMs to provide obstetric first aid Develop guidelines for ANMs/LHVs to use selected life-saving drugs (antibiotics/oxytocin/magnesium sulphate etc.) in obstetric emergencies.	Guidelines developed by April 2005.	Guidelines Government order Modified drugs list Modified supply and availability norms
5.9 Generate awareness regarding institutional deliveries and EmOC Develop and implement IEC/BCC/community mobilization action plan aimed at promoting institutional deliveries, Janani Suraksha Yojana and referral transport funds; and to generate awareness about danger signs requiring EmOC.	Action plan developed by June 2005 Implementation as per the timeline of the agreed action plan Proportion of women and men aware of Janani Suraksha Yojana-danger signs of pregnancy and post-partum period-where to go in case of obstetric emergency-how to access referral transport funds and transport	Action plan Implementation report Survey

Logical Framework Approach (LFA)

Program title : RCH Phase II
Planned Program period : 01.04.2005 – 31.03.2010
Prepared on : 31.3.2005

Department of Family Welfare
Government of India

Outputs/Outcomes	Objectively Verifiable Indicators (OVI)	Means/Source of Verification (MOV)
6. Effective newborn-and child health services, including IMNCI are available and accessible at all levels of the national health system	Proportion of neonates (and mothers) receiving 3 visits by a provider (ANM/AWW/Link volunteer/ASHA) within the first week of birth (with one visit within 24 hours at home or after discharge from the facility for institutional deliveries). ▪ Overall ▪ BPL/SC/ST ▪ EAG & NE states Proportion of neonates who were breastfed on day 1 of life and at 6 months of age ▪ Overall ▪ BPL/SC/ST ▪ EAG & NE states Proportion of infants who were receiving complementary feeds apart from breastfeeding at 9 months of age ▪ Overall ▪ BPL/SC/ST ▪ EAG & NE states Proportion of neonates and children with following illnesses in the previous 4 weeks who received appropriate medication (viz. ORS, antibiotic) as per IMNCI protocols ▪ Diarrhea ▪ Acute respiratory infections ▪ Neonatal sepsis	State reports Surveys

Logical Framework Approach (LFA)

Program title : RCH Phase II
Planned program period : 01.04.2005 – 31.03.2010
Prepared on : 31.3.2005

Department of Family Welfare
Government of India

Outputs/Outcomes	Objectively Verifiable Indicators (OVI)	Means/Source of Verification (MOV)
	BPL/SC/ST neonates and children who made use of private sector care through voucher system or insurance or any other agreed mechanism. Number and distribution of polio cases Reduction in the incidence of vaccine preventable diseases: 1. Utilization rate (BPL/ SC/ST), 2. Client satisfaction (BPL) Proportion of injections given for immunization that are deemed safe AFP surveillance maintained to>=1 non-polio AFP cases per 100,000 under 15 yrs. Immunization coverage: 1. DTP3 2. BCG to measles drop-out rate 3. TT coverage among pregnant women: ▪ Overall ▪ BPL/SC/ST ▪ EAG and NE states	Surveys

Logical Framework Approach (LFA)

Program title : RCH Phase II
Planned Program period : 01.04.2005 – 31.03.2010
Prepared on : 31.3.2005

Department of Family Welfare
Government of India

Activities	Objectively Verifiable Indicators (OVI)	Means/Source of Verification (MOV)
6.1 Improved quality and coverage of routine immunization services		
Set up National Immunization Authority / division	Order constituting authority with its terms of reference.	Medium term strategic plan document
Implement medium-term strategic plan for UIP	Medium term strategic plan for UIP approved and implemented.	Reports from states
Involve private sector in immunization program	New policy guidelines for involving private sector in immunization implemented by 2007.	Policy guide
Develop guidelines for other vaccine preventable diseases	Updated guidelines for surveillance of other vaccine preventable disease available by 2005.	Guideline document
Ensure efficient vaccine supplies and strengthen cold chain system Ensure that 80% of districts reporting no measles stock-outs.	Proportion of districts with no measles stock-out ■ overall ■ EAG and NE states	Report from states Surveys
Ensure that 90% of the cold chain equipment functioning at any given point of time and phased replacement to CFC free equipment completed by 2007.	Proportion of districts with i. functioning cold chain equipment at any given point of time ii. Proportion of equipment phased into CFC free make ■ Overall ■ EAG & NE states	Reports from States Surveys
Develop and implement a safe injection policy.	Guidelines for injection safety and safe disposal,and adverse event monitoring after immunization are finalised and phased plan ready by 2005.	Guideline document Reports from States Surveys

Logical Framework Approach (LFA)

Program title : RCH Phase II
Planned program period : 01.04.2005 – 31.03.2010
Prepared on : 31.3.2005

Department of Family Welfare
Government of India

Activities	Objectively Verifiable Indicators (OVI)	Means/Source of Verification (MOV)
6.2 Achieve polio eradication certification		
Strengthen routine immunisation as above	As above	As above
Implement supplementary immunization campaigns	Coverage of target children	Reports from States
Ensure effective AFP surveillance	Proportion of AFP cases sampled with adequate stool sample	AFP surveillance reports
6.3 Reduce neonatal and child mortality and morbidity		
Develop action plan for implementing a comprehensive newborn and child health strategy incorporating IMNCI approach and including home-based newborn care, based on PIP	Action plan developed by June 2005 Modified job responsibilities of AWW incorporating role to undertake activities to implement comprehensive newborn and child health strategy by June 2005	Action plan Policy decision by DWCD and government order thereof

Logical Framework Approach (LFA)

Program title : RCH Phase II
Planned Program period : 01.04.2005 – 31.03.2010
Prepared on : 31.3.2005

Department of Family Welfare
Government of India

Activities	Objectively Verifiable Indicators (OVI)	Means/Source of Verification (MOV)
6.4 Operationalize IMNCI strategy at all sub-centres, PHCs, all CHCs and all FRUs by 2010 as per schedule	IMNCI strategy implemented according to action plan as per schedule	Reports from States Surveys
6.5 Operationalize IMNCI strategy at village level in at least 125 districts by 2010 as per schedule	IMNCI strategy implemented at village level as per schedugle	DWCD and health department reports from States Surveys
6.6 Improved care of sick neonates, infants and children.		
Develop and implement a BCC approach to promote prevention, early detection, early careseeking, healthful home practices in neonatal and childhood sickness	BCC elements on prevention and care of sick neonates and children incorporated into RCH II BCC strategy: ■ developed by September 2005 ■ implemented throughout RCH II period as per schedule	BCC strategy document Reports from States Surveys on community participation and behaviour change
Develop guidelines for permitting prescription of life-saving drugs by ANMs, AWWs and link volunteers as per the PIP	Guidelines developed by June 2005	Guidelines Government order Modified drugs list Modified supply and availability norms
Develop new guidelines for simplifying disbursement of referral funds to the needy neonates and children	Guidelines developed and disseminated by September 2005	Guidelines statement

Logical Framework Approach (LFA)

Program title : RCH Phase II
Planned program period : 01.04.2005 – 31.03.2010
Prepared on : 31.3.2005

Department of Family Welfare
Government of India

Activities	Objectively Verifiable Indicators (OVI)	Means/Source of Verification (MOV)
6.7 Improve facility-based cared of neonates and children.		
PHCs and CHCs		
Develop guidelines, norms criteria of operationalisation and procedure for certification for providing newborn and child care services by end 2004 at PHCs and CHCs	Guidelines, norms, criteria of operationalization and procedure for certification developed (in conjunction with those for maternal health services) and disseminated by March 2005	Document
Operationalize at least 50% PHCs and 100% CHCs to provide inpatient care to sick neonates and children according to GoI norms by 2009.	Proportion of specified facilities operationalized as per GoI norms ■ Overall ■ EAG & NE states	Reports from States Reports from central teams Surveys

Logical Framework Approach (LFA)

Program title : RCH Phase II
Planned Program period : 01.04.2005 – 31.03.2010
Prepared on : 31.3.2005

Department of Family Welfare
Government of India

Activities	Objectively Verifiable Indicators (OVI)	Means/Source of Verification (MOV)
6.8 FRUs		
Develop guidelines, norms, criteria of operationalization and procedure for certification for comprehensive care of sick neonates and children at FRUs by March 2005.	Guidelines developed by March 2005	Guidelines
Operationalize at least 2000 First Referral Units in a phased manner starting with district hospitals for comprehensive care of sick neonates and children according to GoI norms by 2008: 2009 200 2010 Additional 400 2011 Additional 600 2012 Additional 800	Number of FRUs operationalized in a sustained manner per GoI norms	Reports from States Reports of central teams Surveys
Develop and implement innovative schemes to ensure access to private sector care for sick neonates and children belonging to BPL families	Schemes developed and disseminated by September 2005 Number of neonates and children of BPL families who availed of private sector care through the schemes	Document Reports from States Surveys
6.9 Promote breastfeeding and complementary feeding.		
Develop and implement a nation-wide BCC approach to promote breastfeeding, complementary feeding and feeding during & after illness.	BCC elements on infant and young child feeding incorporated into RCH II BCC strategy by September 2005, and implemented as per schedule during RCH Phase II period	BCC document Surveys on awareness and behaviour change

Logical Framework Approach (LFA)

Program title : RCH Phase II
Planned program period : 01.04.2005 – 31.03.2010
Prepared on : 31.3.2005

Department of Family Welfare
Government of India

Outputs/Outcomes	Objectively Verifiable Indicators (OVI)	Means/Source of Verification (MOV)
7. Reproductive health and nutrition of adolescents especially those who are married or are out-of-school, are improved	Proportion of early marriages Adolescents report improved access to friendly reproductive health and nutrition services in selected districts Adolescents report increased awareness about key reproductive health and nutrition issues	Surveys State reports Surveys

Logical Framework Approach (LFA)

Program title : RCH Phase II
Planned Program period : 01.04.2005 – 31.03.2010
Prepared on : 31.3.2005

Department of Family Welfare
Government of India

Activities	Objectively Verifiable Indicators (OVI)	Means/Source of Verification (MOV)
Main Activities to achieve Output 7		
7.1 Ensure that reproductive health and nutrition needs of adolescents are met	Proportion of adolescents whose reproduction health and nutrition needs are met	Report
7.2 Develop innovative schemes including BCC strategies in selected districts to improve adolescent reproductive health and nutrition	BCC strategies	BCC reports
Learn from NGO experience		

*Detailed inputs are provided in 1.5.6 of Document 2 Chapter 1.

Logical Framework Approach (LFA)

Program title : RCH Phase II
Planned program period : 01.04.2005 – 31.03.2010
Prepared on : 31.3.2005

Department of Family Welfare
Government of India

Outputs/Outcomes	Objectively Verifiable Indicators (OVI)	Means/Source of Verification (MOV)
8. Quality Primary Health Care services provision established for vulnerable groups	Relevant stakeholders especially private providers involved Strengthened networking of referrals	State reports Networking systems

Logical Framework Approach (LFA)

Program title : RCH Phase II
Planned Program period : 01.04.2005 – 31.03.2010
Prepared on : 31.3.2005

Department of Family Welfare
Government of India

Activities	Objectively Verifiable Indicators (OVI)	Means/Source of Verification (MOV)
Main Activities to achieve Output 8		
8.1 Enhance capacities among state and city stakeholders to plan and implement urban health programs		
Enable states to formulate city based plans based on mapping of slums	Guidelines for Urban Health projects by 2004	Dissemination reports
8.2 Strengthen the urban health delivery system and human resources		
Develop and disseminate policy on strengthening of existing facilities in terms of infrastructure and human resources	Policy on strengthening existing facilities and creation of new facilities along with trained staff and infrastructure evolved	Policy document and dissemination reports
8.3 Improve urban health projects for urban slums based upon approved guidelines		
Develop and disseminate guidelines for urban health projects to the states	Development of training curriculum and manuals for program development and implementation	Training curriculum and program development and implementation manuals
Provide training to state level personnel for program implementation		
8.4 Provide funds for fund flow	Fund flow	SCOVA Account

Logical Framework Approach (LFA)

Program title : RCH Phase II
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Prepared on : 31.3.2005

Department of Family Welfare
Government of India

Outputs/Outcomes	Objectively Verifiable Indicators (OVI)	Means/Source of Verification (MOV)
9. Quality Primary Health Care services provision established in tribal areas	■ Improvement in the coverage, accessibility, acceptability and utilization in the Tribal areas ■ Increased promotion of tribal systems of medicine	Surveys and reports

Logical Framework Approach (LFA)

Program title : RCH Phase II
Planned Program period : 01.04.2005 – 31.03.2010
Prepared on : 31.3.2005

Department of Family Welfare
Government of India

Activities	Objectively Verifiable Indicators (OVI)	Means/Source of Verification (MOV)
Main Activities to achieve Output 9 9.1 Assess the unmet needs of RCH services in different tribal areas 9.2 Provide integrated and quality RCH services 9.3 Improve service coverage, accessibility, acceptability and utilization 9.4 Promote community participation and inter-sectoral coordination 9.5 Promote and encourage tribal systems of medicine	Improvement in service coverage	State reports

Reproductive and Child Health Program
Phase II

Finance & Accounts Manual
for
State Health Society/
State Committees on Voluntary Action
&
District Health/RCH Societies

Government of India
Ministry of Health and Family Welfare
New Delhi

(First edition: April 2005)

Disclaimer

While all care has been taken to bring conformity with the General Financial Rules (GFR), Fundamental Rules and Supplementary Rules (FR & SR), Government of India, in case of any dispute or ambiguity regarding any provision of this manual, the GFR and FR & SR will take precedence over the provisions of this manual.

Important

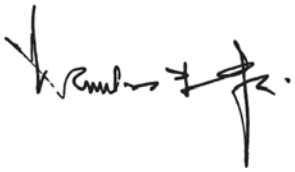
Under NRHM integrated State Health Society and District Health Societies are under process of formation in various States. All the existing socities under the health sector, including SCOVA, are supposed to get merged with the new integrated Society. In such an eventuality, this Manual will be applicable to the newly created State and District Health Socities. Required modification and additions to the Manual, if any, will be notified by Government of India.

Preface

The importance of sound financial management system in health sector, like any other sector, can hardly be over-emphasized. Health sector in fact needs competent finance personnel in as much as medico-technical personnel. It assumes a greater importance in a developing country like India as efficiency of each rupee spent has to be ensured.

It is the mission of Reproductive and Child Health Program to work towards provision of adequate, efficient and prompt healthcare facilities and services for maternal and child health related needs. At the same time, the objective is also to provide a freedom of choice by making available the various quality family welfare services in both public as well as private health facilities to cater to the large unmet needs especially in rural India.

The manual is a diligent effort on the part of Financial Management Group in compiling various financial procedures which are necessary to be complied with by the State Committees on Voluntary Action and District Health & RCH Societies. I sincerely believe that this manual would help the state and district RCH societies in improving their knowledge about the various requirements and ensure their compliance. Any suggestions on the manual are welcome and these would be taken care of in its subsequent editions.



Prasanna Hota
Health & Family Welfare Secretary
Government of India

Acknowledgements

Development of Finance and Accounts Manual for the guidance of State Committees on Voluntary Action and District Health/RCH Societies is a maiden attempt to streamline the process of financial management system in the health sector. It is hoped that the manual will bring uniformity and objectivity in compliance of various procedures and submission of financial reports amongst all the states and UTs in the country.

I gratefully acknowledge the encouragement and guidance given by Shri Prasanna Hota, Secretary, Health and Family Welfare. I am also grateful to Shri S.S. Brar, Joint Secretary (RCH) for his continuous support during the finalization of the manual.

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I would like to express sincere appreciation for the hard work and contributions put by Shri Rajesh Kumar, Shri Sanjay Saxena and Shri Anil Garg, Financial Consultants in bringing out this manual. The manual in its final shape is the result of Shri Rajesh Kumar's tireless contributions.

(P.K. Aggarwal)
Director (RCH-Finance)

RCH PHASE II PROGRAM - Finance and Accounts Manual

Chapters

Appendices

1

Overview of Reproductive and Child Health Program

1.1 Reproductive and Child Health (RCH) Program is the flagship program of the Department of Family Welfare, Government of India. The program was launched on 10th October, 1997, amalgamating the previous programs of Maternal and Child Health (MCH), Child Survival and Safe Motherhood and Family Planning. The program is primarily offered through the Primary Health Infrastructure. The overall goals of the program are to reduce maternal and infant mortality and morbidity and unwanted fertility and thereby contribute to stabilisation of population. The program provides the overarching framework for all the Family Welfare activities. The program receives funding support from World Bank, DFID, European Commission, UNFPA, USAID and other bilateral donors.

1.2 The program has been extended to all the districts of the country and is currently in the 8th year of implementation. Besides implementing and strengthening various activities/interventions of the program, efforts are being made to provide quality services to all and basic services to the unmet pockets.

1.3 During the Tenth Five Year Plan (2002-2007), the main approach of the RCH and Family Welfare Program has been:-

- To assess the reproductive and child health needs of the community and to provide need based, client centred and demand driven RCH care,
- To strengthen the infrastructure for service delivery and bridge the gap in essential infrastructure and manpower,
- To provide additional assistance to identified poor performing districts by ensuring uninterrupted supply of essential drugs and contraceptives, and
- To promote male participation in planned parenthood.

1.4 The National Population Policy adopted in February 2000 affirms the commitment of the Government towards stabilising population of the country by enabling its citizens to make voluntary and informed decisions about their family size. The Policy envisages certain national socio-demographic goals to be achieved by 2010 in order to pave the way for stablizing population in the country by 2045, at a level consistent with the requirements of sustainable economic growth and social development. It also provides a policy framework for advancing goals and prioritising strategies during the next decade, to meet the reproductive and child health needs of the people of India, and to achieve net replacement levels of fertility (Total Fertility Rate viz. TFR = 2.1) by 2010. A range of schemes/ programs have been undertaken to implement the strategic themes listed in the Population Policy for achieving the immediate objective of meeting the unmet needs for contraception, healthcare infrastructure and trained health personnel and to provide integrated service delivery, basic reproductive and child healthcare.

1.5 After completion of the first phase in 2004-05, the Government of India is entering into a Development Credit Agreement with the World Bank for financial assistance of US $ 350 million for the second phase and DFID would be providing an assistance grant of Pound Sterling 250 million. RCH Phase II program will run from 2005-06 to 2009-10.

Reproductive and Child Health Phase II

(A State Plan Based Approach)

1.6 RCH Phase II strives to give a sense of ownership to the States and UTs for running the program. A paradigm shift is being envisaged whereby states are required to prepare and submit state specific Annual Work Plans (AWPs) which reflect the local (state and district) priorities and needs. Government of India would appraise/review the plan and provide lump sum flexi fund to the states and UTs to implement the approved plan.

1.7 The greater ownership being given by GoI to the states to plan and implement the program requires capacity (program as well as financial management) to prepare work plans, implement the program and report on performance against the approved plan.

1.8 The development partners (World Bank and Department for International Development – DFID) have agreed to pool their resources to partly finance this program. The development partners have also agreed to mainstream their financial management and procurement requirements wherein they would depend on internal systems of GoI/ states on the assurance that these would be strengthened and that a sound financial management system would be in place to ensure adequate timely and periodic financial and physical reports and audited financial statements.

1.9 The financial reports/financial statements are powerful management tools. Information from these reports/statements, if analyzed and interpreted properly, leads to better decision-making. It also helps monitor the progress of program implementation and check variance from planned activities and budgets. However, to achieve this, it is necessary to have standardized tools. Hence, this manual has been prepared to assist Program Managers to cull out the relevant information and to assist them in managing the program.

1.10 This 'Finance and Accounts Manual' is an attempt to codify the procedures for budgeting, accounting, financial reporting and auditing systems to enable the implementing agencies of the program to meet the conditions agreed to in the Development Credit Agreement.

RCH Program Components

1.11 Phase II of the RCH program aims to:

- Minimize the regional variations in the areas of Reproductive and Child Health and population stabilization through an integrated, focused, participatory program and meet the unmet demands of the target population.
- Reduce maternal mortality ratio (MMR), infant mortality rate (IMR), total fertility rate (TFR), increase couple protection rate and immunization coverage of children to hundred percent.
- Make provision for common essential package of service delivery mechanisms.
- Ensure that the supply side strategies are oriented to the demand side sensitivities to bring about assured, equitable, responsive and quality service.
- Ensure that the system is geared up to mission mode by using performance benchmarking and accountability tools.
- Overcome the regional variations, differential approaches have been adopted for a group of states at homogenous levels of achievement while designing the program.

1.12 In order to accomplish the above objectives, the program has been divided into following components:

- Infrastructure
- Personnel
- Drugs and supplies
- Operations and Maintenance
- Behavioural Change and Communication and
- Human Resource Development

Program Size

1.13 The indicative program size is approx Rs. 40,000 crores, partially funded by the development partners, and would be made available for 5 years beginning April 2005. Out of this, funds will be allocated to states through the treasury route and to the SCOVAs directly, as earlier. The funds allocated through the treasury route (through the finance department of the states) will be reflected in the respective state budgets and will take care mainly of the salary component of the state government employees involved in the family welfare activities, apart from a few small interventions. Most of the interventions on the service delivery part and actual implementation of the activities will happen with the help of funding through SCOVAs. The flexi-funding will also be at the disposal of the SCOVAs to bring in state/district specific innovations. *An indicative flow chart of the program is given at the end of this chapter.*

Creation of the Financial Management Capacities

1.14 Financial Management brings together planning, budgeting, accounting, financial reporting, internal control including internal audit, external audit, procurement, disbursement of funds and the physical

performance of the program, with the main aim of managing resources efficiently and achieving pre-determined objectives. Sound financial management is, therefore, a critical input for decision-making and program success. Accurate and timely financial information provides a basis for better decisions about physical progress of the program, availability of funds, reducing delays and bottlenecks if noticed. This helps the wheels of progress to move speedily.

1.15 Under RCH Phase II it has, therefore, been the endeavour of the GoI to bring in greater financial management capacities for managing the funds provided through SCOVAs. States found wanting in this respect have been provided with State Program Management Units (PMUs) and District Management Units (DMUs) by the GoI with various key personnel to manage finances professionally.

1.16 It is not enough to have professionally qualified people to man the posts unless they are provided with sector specific knowledge. Financial management cannot operate in a water tight compartment. Thus, induction training for the newly recruited personnel will be provided by the GoI to bring them on board. In addition, the existing finance and accounts staff in all the States/UTs will also be provided with periodic training to keep the finance and accounts managers abreast with latest developments.

Role of Finance & Accounts Managers in Optimum Utilization of Funds

1.17 Under RCH Phase I it has been observed that in many states/UTs, the level of fund utilization has been very poor. While many reforms have been attempted during the implementation phase to increase the level of utilization, they have not shown results in the poor performing states/UTs. On the eve of the launch of RCH Phase II Program, the central government has committed to increase the spending on the health sector from the present level of 0.9% to 2-3% of the GDP. The concern of the central government is that when the states are not able to absorb the present level of funding, increased level of finances will lead to greater level of unutilized money. Thus, the main focus of the DoH&FW under RCH Phase II is to increase the absorption capacity of such states and UTs. While all attempts are being made to strengthen the Program Management Units at state and district levels, it is felt that it is better financial management practices which will ultimately help the managements to aim for greater absorption capacity within the system. The accounts and finance personnel, thus, have a very vital role in the overall scheme of things under the RCH Program.

Finance Management Group At GoI Level

1.18 In order to manage and provide overall guidance and support during the transition to state based planning and program implementation, and to drive the overall financial management arrangements, a Finance Management Group (FMG), headed by Director (RCH Finance) and supported by professionals from various areas of expertise, has been created. In a departure from the earlier practice, all funds of all program divisions will be released centrally by the FMG. The FMG will also monitor the fund utilization centrally. The Finance Managers of the states and UTs will have a dotted line relationship with the central FMG, which will monitor their performance on a continuous basis.

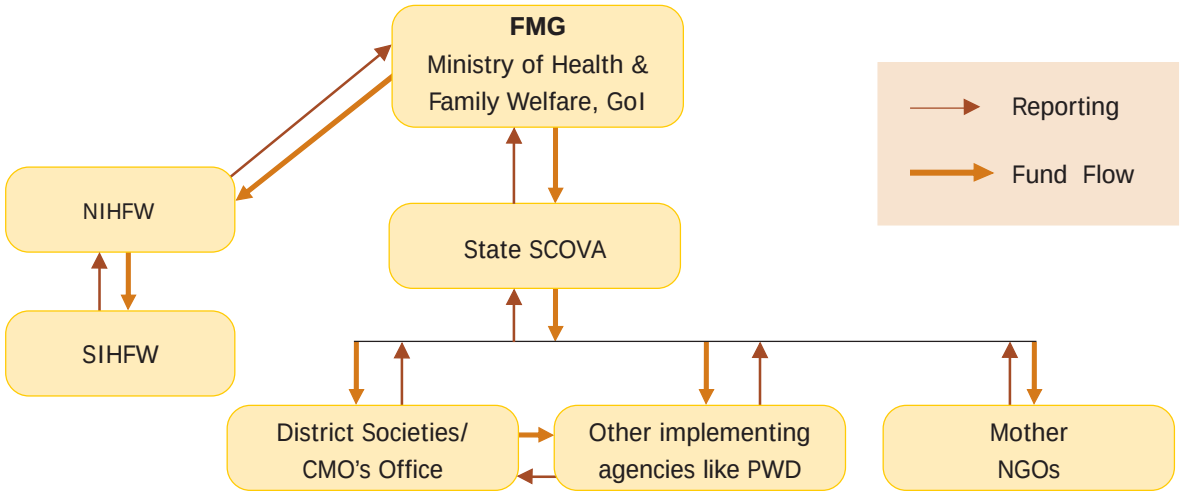
Responsibilities of the FMG

- Process all the fund releases to states/SCOVAs
- Monitor utilization level of states and districts
- Monitor submission of SoEs/ financial reports
- Monitor submission of UCs
- Compile various MIS
- Monitor financial performance indicators
- Take reimbursement from the World Bank
- Oversee the audit arrangements of the SCOVAs
- Monitor submission of audit reports in a timely manner
- Release of advance to NPSA
- Adjustment from non-plan to plan
- Monitor the performance of the bank accredited under e-banking arrangement
- Interact with state-specific divisions on a case to case basis
- Closing and reconciliation of accounts of RCH Phase I
- Training of financial and accounting personnel of states/districts

Financial Management Set-up at State and District Levels

1.19 DoH&FW, GoI has recently strengthened state and district program management units in EAG states by facilitating state and district societies to recruit contractual consultants, including in the fields of finance and accounts. The qualifications and terms of reference for the finance and accounts consultants in the state and district health/RCH societies are given in **Appendix-C.** It is desirable that other states and UTs may also strengthen their financial management capabilities at state and district levels on similar lines.

Figure 1.1 Funds Flow / Reporting Diagram



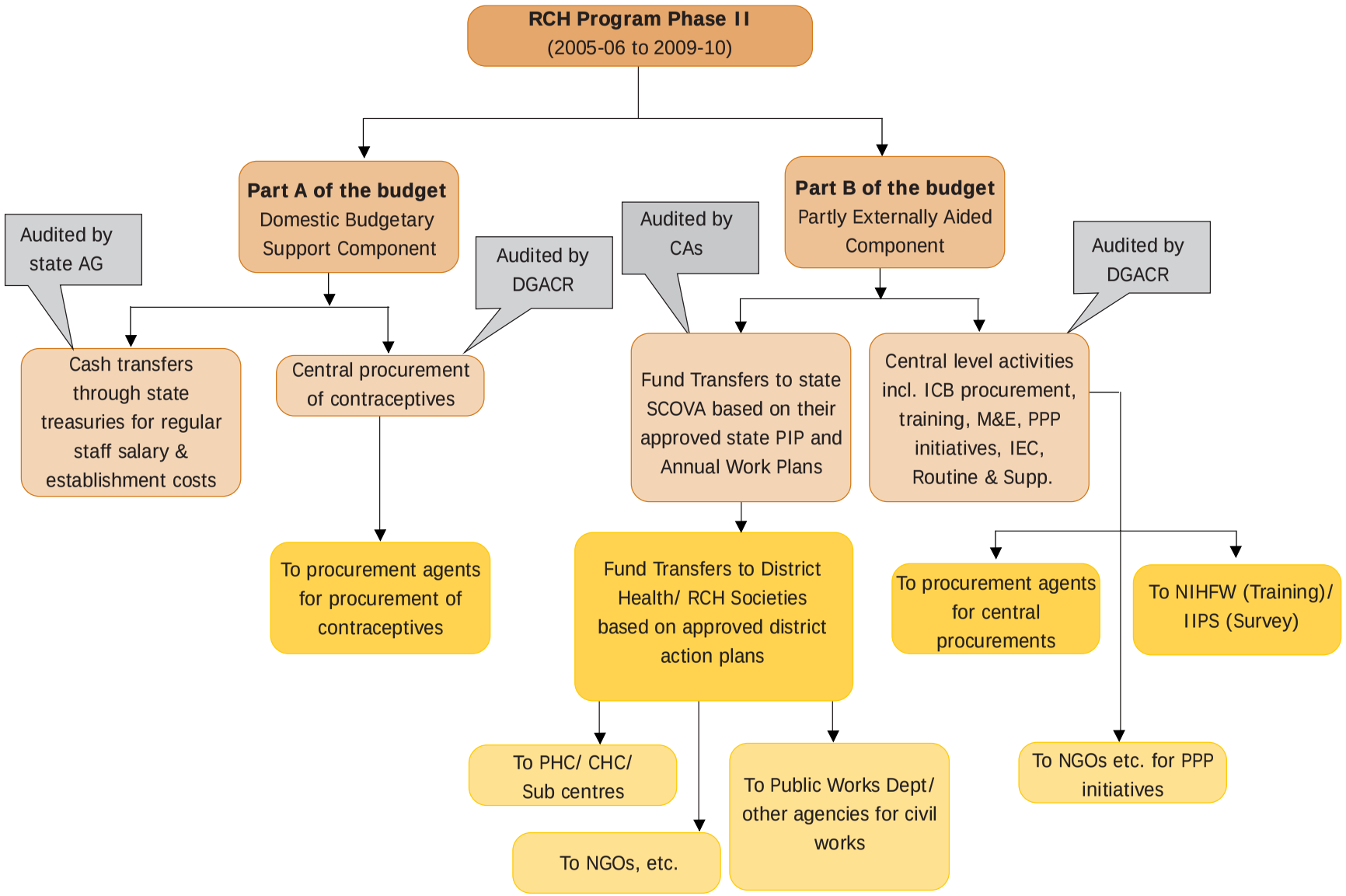
Important: Funds transferred to State SCOVA will be based on the State PIP and subject to the fulfilment of benchmark indicators in second and subsequent years.

Clarifications

1.20 For any clarifications on matter relating to financial management, enquiries can be made from the Director (RCH-Finance), Financial Management Group, Department of Health & Family Welfare, Government of India, Room No. 349-A, Nirman Bhavan, New Delhi (Phone: 011-23062205) (e-mail: fmg.mohfw@gmail.com).

(The FMG welcomes receipt of all correspondence and financial reports on this e-mail address).

Figure 1.2 Funds Flow Diagram of the RCH Program



2

Budgeting and Annual Work Plans

Budgeting & Annual Work Plans

2.1 To implement and monitor the activities during the year, each Implementing Agency in the State (i.e. State Committee on Voluntary Action-SCOVA) and District RCH Society is required to prepare a plan of action indicating inter-alia, the physical targets and budgetary estimates in accordance with the approved pattern of assistance under the scheme, covering all aspects of the program activities for the period from April to March each year, and send it to Department of Family Welfare for approval well before the start of the financial year. The action plan should be realistic and correlate the financial and physical terms.

2.2 From the financial year 2005-06 onwards, funds for RCH related activities would be released from the Department of Family Welfare to SCOVAs based on the approved Program Implementation Plans (PIPs) by way of a flexible pool fund, and to the district RCH societies by the respective SCOVA societies based on their district plans. In order to have a clear idea about the State's RCH budget (SCOVA), funds received from time to time and released to districts at one place, a 'Budget Receipt & Control Register' is required to be maintained at State SCOVA and district RCH Societies in the format given at **Appendix – 1.**

2.3 The monitoring by the GoI will be at the program level. However, to evaluate performance, progress under each activity as proposed by the state in the Annual Work Plan (AWP) and agreed by the GoI, will be monitored. Any changes in the approved AWP may be discussed during the quarterly and annual reviews and implemented by mutual consent. The states/UTs may amend their approved AWP within 10% of any of the sub item(s) so as to have flexibility in inter-component use of funds without affecting the overall outlay approved for the state/UT for the year. Activity-wise performance evaluation will then be synchronized with the revised work plan. In all such cases FMG, GoI will necessarily be informed of this revision.

Figure 2.1: An Outline of the RCH Phase II Implementation Process at the National Level

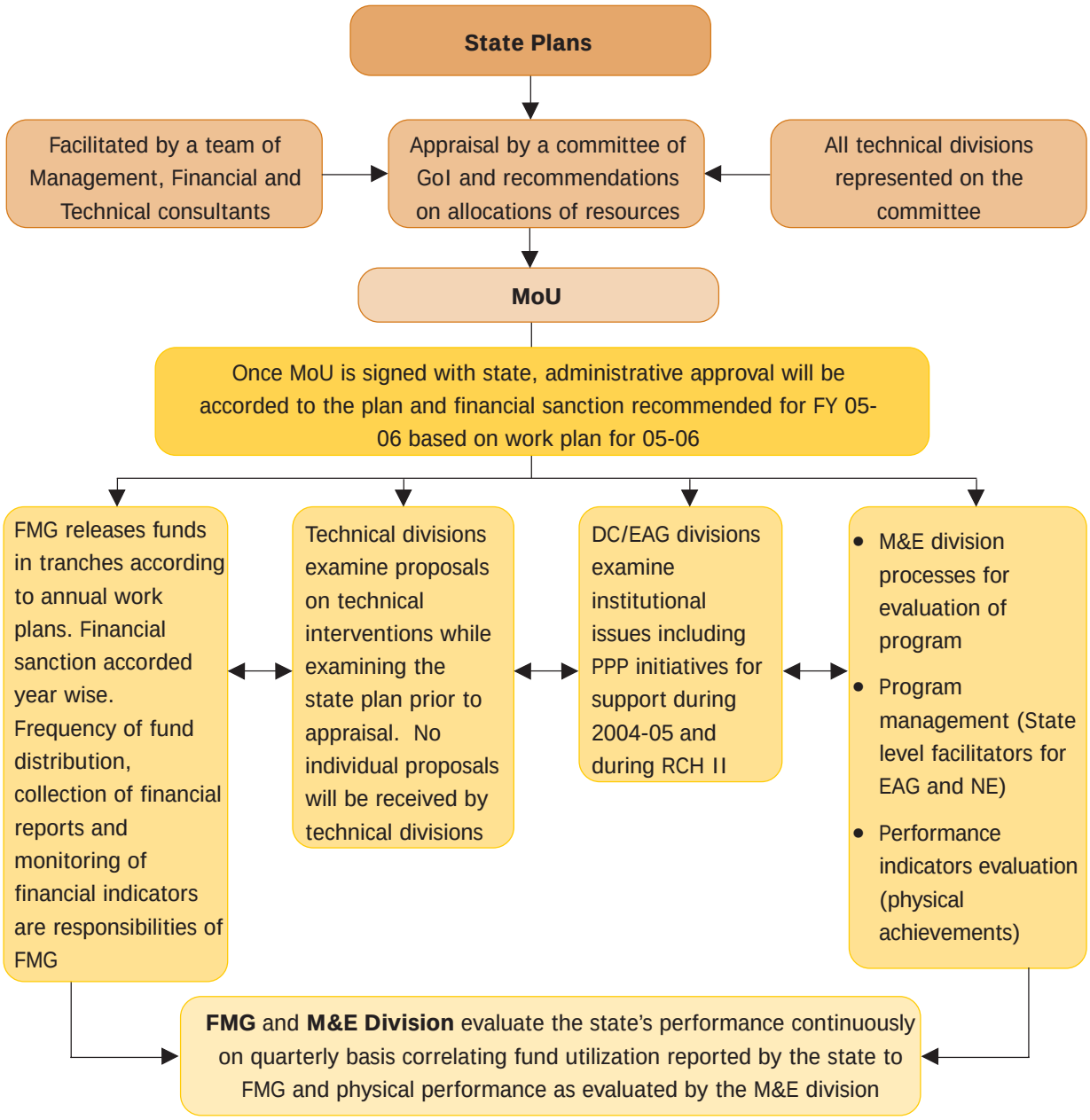


Figure 2.2 Important Dates for Submission and Approval of Annual Work Plan

Activity	Date
Last date of submission by State/UT to GoI	31st December of the previous financial year
Last date for approval by GoI	28th February of the previous financial year

3

Funds Flow Arrangements

3.1 The Government of India, Department of Family Welfare would be providing the funds to SCOVAs through its budgetary resources.

3.2 **Funds of the State Committee on Voluntary Action (SCOVA)**

- The funds of the SCOVAs would consist of grants-in-aid made by or through Government of India, Ministry of Health and Family Welfare, Department of Family Welfare or the State Government.
- All moneys received by way of grants, gifts, donations, and benefactions, transferred in any other manner from any source other than the government.

3.3 **Transition arrangements for unspent funds from RCH Phase I**

- Since RCH Program is an ongoing program, the unspent balances lying with the SCOVAs as on 31st March 2005, will be carried forward to RCH Phase II Program, which will be launched on 1st April 2005, if the same activities for which funds were granted during RCH I find place in the approved PIP of the states/UTs under RCH Phase II. Funds granted during RCH I for the activities which are not planned under RCH II need to be refunded to the MoH&FW, GoI.
- **However, funds carried forward from RCH I to RCH II need to be reported to the FMG, GoI for reallocation to RCH II.** Since the funds under RCH I were provided for specific activities, Utilization Certificates (UCs) would need to be furnished for the amount which is carried forward to RCH II separately. The SCOVAs will need to furnish the Utilization Certificates for each activity under which unspent balances have been carried forward at the end of March 2005 in the following manner in form GFR 19A:

"Certified that out of Rs. _____ of grants-in-aids sanctioned during the financial year (YYYY–YYYY) in favour of the State SCOVA (Name of State) by the Department of Family Welfare, Govt. of India vide letter nos. (mentioned above in format of UC) and Rs. _____ on account of unspent balance of the previous year (s), a sum of Rs. _____ has been utilized for the purpose for which it was sanctioned and that the balance of Rs. XXXX remained as unutilized at the end of the year, will be adjusted towards the grants-in-aid payable during the next year. " (excerpt from **Appendix-6)**

- The states/UTs will need to utilize this re-allocated amount preferably in the first year of RCH II (i.e., 2005-06) itself so that the UCs for the amount can be furnished separately and from the second year onward this complication is not faced.

Frequency of Funds Release and Conditions Precedent

3.4 Based upon the approval of the Program Implementation Plans (PIPs) and Annual Work Plans (AWPs) of the states/UTs by National Program Coordination Committee (NPCC), and the submission of Letter of Undertaking/Understanding by the states/UTs, the first tranche of funds will be released in the first year, which will be 50% of the first year's requirements. The release of second tranche of funds from Ministry of Health and Family Welfare (MoH&FW), Government of India in the first year would be made subject to fulfilment of basic Financial Management Indicators relating to *HRD* and *Empowerment* (Parts A & B of the Financial Management Indicators). Fulfilment of all Financial Management Indicators (Parts A, B & C of FM Indicators) would be necessary for release of funds in the second and subsequent years. In addition, from the second year onwards it will be necessary for the states/UTs to sign a Memorandum of Understanding (MoU) with the MoH&FW, GoI and achievement of at least half the institutional process targets specified in Annex III A of the MoU to access further funds. The NPCC will determine the value of releases from fiscal year 2008/09 onwards in the light of state/UTs achievement of the output targets specified in Annex III B of the MoU, as verified by means of mid-term and end-line survey.

3.5 Funds will be released biannually, subject to above mentioned conditions precedent.

3.6 The financial management indicators have been evolved for ensuring smooth flow of funds from the center to the states/ UTs and from states/ UTs to the districts and timely reporting of funds Utilization, for taking timely corrective action, wherever needed and for overall financial management of RCH Phase II Program. *(Financial Management Indicators are at* **Appendix - 2**).

3.7 Information on financial management indicators as per **Appendix-2** need to be furnished to the FMG, MoH&FW on half yearly basis before every release of tranche during the first year of the start of the program. The dates for submission of FM indicators will be **30th September** and **31st March** during the year 2005-06. In the subsequent years it will be required to be sent once on 31st March.

3.8 50% of the annual funds requirement for the first year as per the approved Annual Work Plan (AWP) shall be released upon execution of the MoU, approval of State's Annual Work Plan and launch of the RCH Phase II program, thereafter biannually, based on the agreed milestones of performance and the RCH program spending pattern according to the work plans in the PIP.

Figure 3.1: Tranche Release Arrangements

	Tranche	Month	Conditions Precedent
YEAR – 1	**First Tranche**	**by 30th April**	■ As per approved annual plan for first 6 months.
	Second Tranche	**by 15th November**	■ Based on the expenditure reported in the first two quarters. ■ Fulfilment of basic financial management indicators relating to HRD and empowerment **(Appendix – 2, Parts A & B).** ■ Submission of Letter of Undertaking by the states/UTs to GoI.
YEAR – 2 onwards	**First Tranche**	**by 15th May**	■ As per the approved annual plan for first 6 months. ■ If the unspent balance with SCOVA is less than 6 months requirement, full first tranche will be released. If the unspent balance with SCOVA is more than first 6 months requirement, then no fund will be released. ■ Fulfilment of all Financial Management Indicators (Parts A, B & C) in **Appendix-2.** ■ MoU has been signed between the State/UT Government and the MoH&FW, GOI. ■ Achievement of at least half the institutional process targets specified in Annex III A of the MoU.
	Second Tranche	**By 15th November**	■ Provided audited accounts, UCs are submitted for the first year and SOE for the first two quarters is also submitted. ■ All other conditions as mentioned for the first tranche are met.

3.9 Funds will be passed on directly into the savings bank accounts of the SCOVAs by the Department of Family Welfare, GoI.

Release of Funds by State SCOVA to Districts

3.10 It has been the experience during RCH Phase I that funds received from the GoI remain idle in the bank account of SCOVA for months together. This is tantamount to sheer wastage of national resources in the pipeline when the money meant for the beneficiaries does not reach them in time. **Therefore, it will be mandatory on the part of SCOVAs to transfer funds to the districts within 15 days of the receipt of funds from the GoI. A certificate to the effect that the funds have been transferred to district societies as per their district Annual Action Plans, has to be furnished to the FMG, GoI.**

Figure 3.2

The following certificate should be furnished to the FMG, GoI on the dates specified below by the State Finance Manager/Project Director/ED	
"Certified that out of Rs._____ received through the (FIRST/SECOND) tranche of the year 200_-200_ from the GoI on (dd/mm/yyyy), Rs._____ have been transferred to the account of District Societies on (dd/mm/yyyy) as per their District Action Plans."	
	Date on which the certificate needs to be furnished to the FMG, GOI
For Year 2005-06	
First Tranche	By 30th May
Second Tranche	By 15th December
For Year 2006-07 onwards	
First Tranche	By 15th June
Second Tranche	By 15th December

3.11 Procedure for release of funds

- The Society funds shall be drawn through cheques and/or bank drafts.
- All cheques shall be signed by two authorized signatories of the Finance and Administration Division on the basis of a written authorization from the concerned program manager/consultant and/or Head of concerned Division and/or Executive Director and/or Director Health Services.
- Wherever releases are decided to be made through bank drafts, the authorization letter to the bank shall be signed by the concerned authorized signatories.
- In case electronic banking (e-Banking) is introduced by the Government of India for fund release and day-to-day payments for program implementation, separate detailed guidelines will be issued by the Government of India for effecting fund transfer and execution of payments.
- In all cases where funds are to be released on the basis of approved plans, the concerned program manager shall prepare a 'request for release' proposal for issue of cheque/draft by the Finance and Administration Division. The 'request for release' shall be routed to the Finance and Administration Division through the concerned Head of Division and shall be accompanied by (a) a copy of the agenda papers of the relevant meeting of the Governing Body/Executive Body and (b) a copy of the minutes of the relevant meeting indicating approval of the proposals.
- In all other cases, proposals shall be initiated by the concerned division and sent to Finance and Administration Division after obtaining the approval of the appropriate authority, depending on the sum involved.

Maintenance of Bank Accounts by State Scova Society

3.12 All moneys credited to the funds of the society under RCH Program shall be deposited in a savings bank account of a RBI scheduled bank approved by the Department of Family Welfare, Government of India. The societies having an account with the existing bank may continue unless otherwise intimated by the Government of India. For speedy release of funds from the centre to the states/ UTs and from the states to the districts, an e-banking solution is likely to be introduced soon by the Department of Family Welfare, GoI. The detailed guidelines for the same will be provided in due course.

4

Accounting Policies, Heads of Account & Financial Reporting

4.1 The state and the district societies which receive funds in addition to the proposed flexible pool of funds against approved annual work plans shall maintain separate bank accounts and separate books of accounts in respect of funds received under other bilateral projects viz. DFID, USAID, EU, UNFPA, WHO, etc. under the RCH program.

Accounting Policies

4.2 In order to ensure uniformity and consistency in the method of accounting for program funds and financial reporting, the following accounting policies will be applicable. The periodic financial reporting and the annual financial statements will be guided by these accounting policies and principles. In some cases there are some deviations from the accounting standards prescribed by the Institute of Chartered Accountants of India, e.g. Depreciation Policy.

Some of the key accounting policies are:

Maintenance of Accounts

4.3 The accounts of the Society shall be maintained on double entry book keeping principles, on cash basis of accounting. Standard books of accounts (cash book, journal, ledger, etc.) shall be maintained in accordance with the accounting policies being given hereunder:

- Basis of preparation of Financial Statements

  The financial statement has been prepared on the cash basis of accounting and the applicable accounting standards issued by the Institute of Chartered Accountants of India subject to certain exceptions which are listed below.

- **Fixed assets**

  Fixed assets are stated at cost of acquisition and subsequent improvements thereto including taxes, duties, freight and other incidental expenses relating to acquisition. Capital fund, equivalent to cost of fixed assets purchased during the year, is created.

  For the purpose of fixed assets only those assets are counted which are directly purchased for the use in the premises of the state and district society offices and the vehicles purchased for the use of society. (see Chapter-VI under the para 'Register of Fixed Assets' for details).

- **Investments**

  Investment in FDRs or any other instruments are current investments and are stated at cost.

- **Depreciation**

  Depreciation on fixed assets is not provided as assets are generated out of Grants-in-Aid (GIA). However assets are disposed of/ condemned as per the provisions under General Financial Rules (GFR) of state/UT governments or GoI.

- **Recognition of Income / Expenditure**
  - The Grant-in-Aid (GIA) is accounted on cash basis
  - The Grant-in-Aid (GIA) is reflected in the Income & Expenditure accounts as income to the extent of fund utilization against it.
  - The Grant-in-Aid to the extent it remains utilized at the end of the financial year is shown as liability in the balance sheet.
  - The advances to the hospitals/CHC/PHC/medical officers etc. are treated as expenditure if the individual advance was Rs.5000/- or below. All the advances above this limit will stand as advance in the books of account and will be adjusted as expenditure only when the accounts, utilization certificates are submitted by these agencies as proof of utilization.
  - The funds released against the works are considered as 'Deposit' under capital work in progress. The 'deposit' will be cleared on the basis of progressive report on work completion and the reported amount for which the work has been completed will be booked as final expenditure.
  - 'Other income' – interest income, income from investments are accounted on cash basis.
  - The Grants-in-Aid to NGOs are treated as expenditure at the time of release; however monitoring is done through 'Memorandum Accounts'.
  - Commodity grants received from the Government of India relating to the RCH program are not reflected in the financial statements of the society.

- **Accounting of assets acquired under assisted program (other than GoI)**

  The assets acquired out of funds from agencies (other than GoI) are also capitalized and equivalent amount is transferred to 'Capital Fund'.

- **Notes and disclosure of accounting policies**
  - The basis of preparation of financial reports and significant accounting policies related to material items shall be disclosed. Any changes from earlier policy may be disclosed along with the impact of such a change on financial indicators.

- The notes should provide additional information, which is not readily discernible from the financial reports but is necessary for a fair presentation of the entity's financial performance and position.
- Notes to the financial reports should be presented in a systematic manner. Each item in the statements should be cross-referenced to any related information in the notes.

Maintenance of Accounts Records

4.4 A record of all program transactions shall be maintained with appropriate supporting documentation for the transactions. These supporting documents should be cross-referenced so as to link them to each item of expenditure with budget heads, project components, expenditure categories (summary and detailed) compatible with classification of expenditure and sources of funds indicated in the project implementation plan and project cost budget sheets. These books of accounts together with supporting documents and project management reports should be maintained for at least three years after the completion of audit of the entire program expenditure, i.e., at least three years after the completion of RCH Phase II Program.

Heads of Accounts

4.5 In order to keep proper financial information on the program activities, the standard ledger heads for each component and sub-ledger heads for all the categories under these components shall be maintained. All expenditure incurred by a society shall be booked under the account heads maintained in respect of various items of expenditure relating to these components. A statement of ledger account heads is indicated in **Appendix - 3.**

4.6 Detailed procedures and guidelines for maintenance of books of accounts at district RCH societies and state SCOVA are given in the next chapter.

Submission of Financial Reports

4.7 All the districts would send a monthly financial report to the state SCOVA by the 10th of the following month in respect of expenditure incurred by them as per the format given in **Appendix – 4.** In case the information is not received from the districts by 10th, the state SCOVA will immediately contact the district RCH Society/CMO to get the information expeditiously. In some cases concerned district officials may have to be asked to personally bring the information to ensure compliance. In case districts neither furnish the information nor bring the information personally, the state officials may be deputed to look into the problems of the district in giving the information and set it right for future.

4.8 A format of financial report which is required to be furnished quarterly within 30 days from the close of each quarter by the state SCOVAs to the center is given in **Appendix - 5.** As stated in the above para, the state SCOVA must ensure receipt of information from all the districts, compilation, and furnishing of the same to the MoH&FW, GoI within the stipulated date without fail and no excuse will be acceptable on this count.

Figure 4.1: Various Reports and Important Dates for Districts

S. No.	Report	Date on which to be sent	Responsibility	Assisted by	To whom	Remarks
1.	**Monthly Financial Report**	By 10th of the following month	**CMO/CDMO/ CHMO/CS**	District Accounts Manager/ Accounts Officer/ Accountant	**ED/Proj. Dir./State Finance or Accounts Manager**	The timeliness of submission will be monitored and entered in the evaluation sheet of the District Accounts Manager by CMO.
2.	**Monthly Program Implementation Report**	By 10th of the following month	**CMO/CDMO/ CHMO/CS**	District Program Manager/AO/ Accountant	**ED/Proj. Dir./State Program Manager**	The timeliness of submission will be monitored and entered in the evaluation sheet of the District Program Manager by CMO.

Figure 4.2: Various Reports and Important Dates for State/UT SCOVA

S. No.	Report	Date on which to be sent	Responsibility	Assisted by	To whom	Remarks
1.	**Quarterly Financial Report** ***(Appendix - 5)***	▪ **1st Quarter** (April-June): **31st July** ▪ **2nd Quarter** (July-Sept): **31st Oct** ▪ **3rd Quarter** (Oct – Dec): **31st Jan** ▪ **4th Quarter** (Jan-March): **30th April**	**Executive Director/ Project Director** SCOVA	State Accounts Manager/ Accounts Consultant/ AO	**FMG, GoI**	The Consolidated Financial Report of the state/UT shall be sent on due date to GOI without fail. The reports of the districts which have not submitted the report to state SCOVA on time will be excluded and will be included in the financial report of the next quarter. The state will inform the names of the districts whose accounts have been excluded, **along with the details of period of delay,** i.e., the months for which the accounts of a particular district have been excluded. The state/UT will also inform the GOI about the reasons for delay and steps taken to avoid such delays in future. The timeliness of submission will be monitored and entered in the evaluation sheet of state Accounts Manager by the ED/Proj. Dir. SCOVA.

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S. No.	Report	Date on which to be sent	Responsibility	Assisted by	To whom	Remarks
2.	**Audited Statement of Accounts and Audit reports of SCOVA**	By 31st July of the following year	**Executive Director/ Project Director SCOVA**	State Program Manager	**FMG, GoI**	The timeliness of submission will be monitored and entered in the evaluation sheet of State Program Manager by the ED/Proj. Dir. SCOVA.
3.	**Utilization Certificate**	By 31st July along with the Audited statements	**Executive Director/ Project Director SCOVA**	State Program Manager	**FMG, GoI**	There will be ONE consolidated Utilization Certificate (UC) for the grants received from GOI during a particular year. The UC will be submitted in Form No. GFR 19A **(Appendix-6)** There will be no differentiation between types of grants – recurrent or non-recurrent – in this regard. Separate UCs will be required for funds carried forward from RCH Phase I.

4.9 The state SCOVA will evaluate the performance of the contractual Finance and Accounts staff by suitably devising a performance appraisal format/sheet which will inter-alia include her/his performance vis-à-vis Financial Performance Related Indicators as mentioned in paras C.1, C.2 & C.3 of the Financial Management Indicators **(Appendix-2)**. A copy of this performance appraisal sheet will be forwarded to the Financial Management Group (FMG), GoI for getting concurrence for the yearly extension of tenure of the Finance and Accounts personnel. Pending feedback from the Central FMG, the SCOVAs will be empowered to extend the tenure up to six months.

4.10 A similar procedure may be followed by the state/UT SCOVAs to evaluate and monitor the performance of accounts and finance staff of the district RCH societies.

Utilization Certificate

4.11 In respect to the grants-in-aid received from the Government of India, the Society shall furnish a "Utilization Certificate" (UC) in Form No. GFR 19A duly signed by the ED/Project Director to Department of Family Welfare, GOI along with the audited annual financial statements. A copy of the format of Utilization Certificate is at **Appendix-6.** The UC is required to be submitted by 31st July every year along with the audited statement of expenditure. Since under RCH-II, there would be a lump-sum sanction of grant-in-aid to SCOVA for various activities, a single UC would suffice for the sanctions of RCH. However, separate UCs would be necessary for grants-in-aid released for Pulse Polio, EC-SIP project, UNFPA IPP area projects, etc. for which separate sanctions and funds were released.

4.12 All Grants-in-Aid sanctioned and released by the Government of India to SCOVA in a particular financial year shall be indicated by the Society in its Utilization Certificate of that financial year, irrespective of the fact that the amount is received by the society in the subsequent financial year.

Review / Revision of Financial Powers

4.13 The Governing Body may review and revise the financial powers of the office bearers of the bodies of the Society on an annual basis and revise the same, if considered necessary.

Delegation of Financial Powers

4.14 To ensure smooth, fast and efficient utilization of funds for the purpose(s) for which these are released by the Government of India, the GoI has prescribed a model Delegation of Financial and Administrative Powers to State/UT Governments both at State SCOVA and District Health/RCH Society levels. Model Delegation of Financial and Administrative Powers is annexed at **Appendix-A** and **Appendix-B**. Financial Management Indicators at **Appendix-2**, read with Para 3.4 of this Manual, makes it clear that the states need to delegate financial and administrative powers to the functionaries of state SCOVA and District Health/RCH Societies before the release of second tranche of the first year of launch of RCH Phase II Program to access further funds.

4.15 The society shall function on the basis of the delegation of such financial and administrative powers, which have been delegated by the Governing/Executive body of the society or through the Government Order of the state/UT Government.

Miscellaneous

4.16 The income and property of the society, howsoever derived, shall be applied towards the promotion of the objectives thereof, subject nevertheless to financial discipline in respect of the expenditure of grants imposed by the central government from time to time.

4.17 If on the winding up or dissolution of the Society there shall remain after satisfaction of its debts and liabilities, any property whatsoever, the same shall not be paid to or distributed among the members or any of them, but shall, consistent with the objectives of the society, be dealt with in a manner determined by the Central Government.

5

Audit of Accounts of State SCOVAs and District Health/RCH Societies

5.1 In order to have satisfactory financial accountability it is essential to have an effective audit system for all state SCOVAs and District RCH Societies in each state/UT, which are implementing and monitoring RCH Phase II Program.

5.2 Audit will be of two types – Internal and External.

External Audit

5.3 **Purpose:** The purpose of external audit is to decide whether the financial statements of the state and district SCOVA represent a true and fair view of the financial position as at end of the financial year and of the operations for the year ended on that date. Primarily external audit, for the purpose of the submitting audited financial statements to the MoH&FW, GoI, will be carried out by a firm of chartered accountants appointed from a list provided by the MoH&FW, GoI. In addition, the C&AG of India through State AGs may carry out a supplementary audit under the C&AG "Duties, Powers & Conditions of Services Act, 1971."

Internal Audit/Management Audit

5.4 **Purpose:** The purpose of internal/ management audit is to determine whether the financial management arrangements including internal control mechanism as developed are working effectively and to identify areas for improvement and enhancing efficiency. The primary internal audit / management audit will be carried out by the DoH&FW either on its own or through an outsourced arrangement. In addition, the SCOVA may be audited by Internal Audit by the State Directorate of Health & Family Welfare or by State Finance Department or by any other agency

assigned the task by the state/UT or by the audit team of the Chief Controller of Accounts, Ministry of Health and Family Welfare, Government of India.

5.5 Indicative guidelines for conducting various kinds of audit are given in **Appendix – 13.**

Brief Description About Audit Systems

5.6 **Internal checks**

- The Executive Director/Project Director of state SCOVA, State RCH Program Officer, Consultant (Finance) and District RCH Program Officer will ensure that the returns and statements about expenditure and physical progress are prepared accurately and submitted to the authority concerned within the prescribed time limit.
- Above mentioned officers will also ensure that District Profiles, District Plans, Perspective Plan and Annual Work Plan and Budget Estimates are prepared correctly by state SCOVA & each district RCH society and are submitted to the higher authorities.
- Critical report about Budget provision V/s Physical Progress and expenditure incurred shall be prepared after analyzing the SoEs and Program Progress Reports with due care and attention by the Consultant (Finance) and submitted to the chairperson of Executive Committee of state SCOVA and DoH&FW as per time schedule.
- Visits of officers of state SCOVA to the district RCH societies and visits of officers of the DoH&FW, especially the officers of Financial Management Group (FMG) at state and district level for spot inspection of accounts and financial management system on random basis.
- Consultant (Finance) shall form a team and chalk out program for field visits and ensure that each district RCH society or any other program implementing agency are visited at least twice in a financial year.

5.7 An indicative checklist on basic financial controls is given in **Appendix-13A.**

Internal Audit System

5.8 Internal Audit is a method of control that functions by examining and evaluating the adequacy and effectiveness of other controls throughout the organization. The internal audit activities should include pre-payment audit as well as independent appraisals of the financial, operational and control activities of the program. The responsibilities of internal auditors should include reporting on the adequacy of internal controls, the accuracy and propriety of transactions, the extent to which assets are accounted for and safeguarded, and the level of compliance with RCH II financial norms and procedures of the manual.

Procedure For Internal Audit System

5.9 **District level**

- The Executive Director/Project Director of SCOVA with the help of the State Finance Manager/ State Accounts Manager/Consultant (Finance) shall ensure proper arrangement for internal audit of each district RCH society and other program implementing agencies in the state, which should be finalized well before the close of each financial year.

- This internal audit will be carried out by the team of State Finance Manager/State Finance Consultant and State Accounts Manager/State Accounts Consultant on a sample basis. The sample of district societies will be chosen by the Executive Director/Project Director SCOVA. A system should be put in place which will ensure that each major program implementation district society is audited at least once in two years.

5.10 **State level**

The state SCOVAs and other RCH program implementing agencies will be audited by the teams from the MoH&FW, GOI on a sample basis. In addition the internal audit team of the Chief Controller of Accounts, Ministry of Health and Family Welfare, GoI will also conduct audits on a sample basis.

Notes: A List of Points to be kept in view while conducting audit is given in **Appendix – 14.**

Appointment of External Auditors

5.11 DoH&FW, GoI will furnish a panel of Chartered Accountant firms drawn from the panel maintained by the Comptroller and Auditor General of India (CAG). The firm would be selected out of this panel by states/UTs based on certain criteria like experience of firm, experience of partners, and strength of partner. The selection process should be transparent and well documented. The selection process will be subject to review by the Internal Audit parties of the Chief Controller of Accounts, Ministry of Health and Family Welfare, GoI, and the audit team of the CAG. A chart giving the criteria for evaluating CA Firms is given at **Appendix- 14-A**.

Figure 5.1: Important Activities and Dates for External Audit

S. No.	Activity	Date	Remarks
1.	**List of Chartered Accountant Firms from GoI to States/ UTs**	By 31st December of the year for which audit is to be done	
2.	**Contacting the firms from the list provided by GoI**	By 31st January of the year for which audit is to be done	■ The firms will be contacted by sending Request for Proposal – including Letters of Invitation & TOR by registered post with acknowledgement. ■ It should be made clear in the invitation letter that only 'Technical Bids' will be accepted in a sealed envelope. No financial bid is to be provided by the CA Firms. ■ It should also be made clear at this stage that only the firm found most suitable in the evaluation of technical bid will be awarded the audit work.

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S. No.	Activity	Date	Remarks
			■ The dates for opening the 'Technical Bid' will be clearly mentioned in the invitation letter. ■ It will also be mentioned in the invitation letter that the 'Technical Bid' will be opened in the presence of representatives of the Chartered Accountant firms who have applied. ■ A copy of the Terms of Reference (TOR) should be given to each firm.
3.	**Last date for accepting the technical bids**	By 28/29th February of the year for which audit is to be done	
4.	**Date for opening the Technical Bids**	Same date as of accepting the technical bids	Same day of accepting the technical bid. Evaluation etc. Give criterion of evaluation – Standard Evaluation Form.
5.	**Date for intimating the selected auditor**	Within next FIFTEEN WORKING DAYS of opening the Technical Bids	The technical bids will be evaluated by a committee duly appointed by the Executive Body of the state SCOVA as per the Standard Evaluation Sheet given at **Appendix-14A.**
6.	**Last Date for appointing the auditor**	By 31st March of the year for which audit is to be done.	■ The appointment letter will clearly mention the date on which the accounts of the SCOVA and district societies will be made available to the auditor for audit. ■ A copy of this **'Finance and Accounts Manual'** will be made available to the auditor along with the appointment letter.
7.	**Completion and finalization of accounts of all the district health/RCH societies**	30th April of the following year	
8.	**Completion of audit of district health/RCH societies**	31st May of the following year	If the accounts of the SCOVA and the district societies are not made available to the auditor, the auditor will be free to inform the GoI about the delay.
9.	**Consolidation of accounts of all districts health/RCH societies with the accounts of state SCOVA**	15th June of the following year	

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S. No.	Activity	Date	Remarks
10.	**Completion of audit of state SCOVA**	30th June of the following year	
11.	**Submission of audit report to MoH&FW, GoI along with management letter and society's comments on it and UCs**	31st July of the following year	
12.	**Signatories to audited Statement of Accounts**		Executive Director/ Project Director/ State Program Manager/ State Finance Manager and the Auditor.

5.12 The appointment of External Auditor shall be made by the governing board of the concerned state SCOVA, on the recommendations of its Executive Committee. It is recommended to appoint the same auditors for all centrally sponsored schemes being undertaken through state SCOVA. This would ensure annual audit for the SCOVA society as a whole and the same audit report could then be used to submit the Income Tax Return. For short-listing the firms of Chartered Accountants, expression of interest may be obtained as per the format in **Appendix -15.**

5.13 As being done presently, the auditors at the state level, who would be the 'Principal Auditors' for the SCOVA society will be appointed after inviting both technical and financial bids from the firms empanelled with CAG or DoH&FW not necessarily located in the state/UT concerned.

5.14 The audit of accounts shall cover the SCOVA society office and all district societies. Auditors appointed for the audit of state SCOVA should preferably do the audit of district health/RCH societies. In addition, a few other RCH Program implementing agencies like the CHCs/PHCs may be selected on a random basis for audit of their RCH implementation activities. The Chartered Accountant firm should complete the audit work by 30th June every year.

5.15 The objective of the audit of the financial statements is to enable the auditor to express a professional opinion on the financial position of the progress as at 31st March of the previous year and the funds received and expenditure incurred for the accounting period ended March 31 of each financial year. In addition to the audit report, the auditor will prepare a 'Management Letter' to comment upon accounting policy, internal control, specific deficiency or area of weaknesses noted in the system etc.

5.16 Indicative terms of reference (TOR) of audit by Chartered Accountants firm is given in **Appendix-16**.

5.17 After completing the audit work of the state SCOVA society and its district societies, the external auditor has to express his opinion on the financial statements prepared by the state SCOVA staff. The audit report must accompany the following financial and other statements:

- Receipt and Payment account (**Appendix-17**)
- Income & Expenditure account (**Appendix-18**)

- Balance Sheet (**Appendix-19**)
- Statement of fixed assets in the form of a schedule (**Appendix-20**)
- Schedule of loans and advances
- Auditor's report as per the format given in the appendix (**Appendix-21**)
- Management Letter with comments of the state (**Appendix-22**)
- All significant accounting policies
- Notes to accounts
- List of outstanding liabilities as notes to accounts
- Utilization Certificate (**Appendix-6**) and
- Bank Reconciliation Statement (**Appendix-9**)
- Compliance report on pending Audit observations of last year(s)
- Comparison between the audited accounts and the SoEs/financial reports submitted to GoI by the SCOVA

5.18 The above documents shall be prepared by the State Accounts Manager/State Finance Manager/ Associate Consultant (Accountant) with the help of Data Manager/Computer Accountant at SCOVA and by the District Accounts Manager/Accounts Executive with the help of Data Manager/General Assistant (I.T.) at District Health/RCH Society latest by 30th April. These will be thoroughly examined by the Chartered Accountant and authenticate by putting their signature and seal of the office. All such formalities shall have to be completed by 30th June every year by the external auditor and submit three original sets of the annual audited accounts.

5.19 The Executive Director/Project Director of each state SCOVA/UT shall submit audited accounts before the Executive Committee in its next meeting along with his comments on the points mentioned in the Management Letter and notes on accounts by the external auditor. After approval the accounts shall also be submitted to the Governing Body of the State SCOVA for its approval. Thereafter these accounts along with Utilization Certificate will be submitted to the Director (Finance-RCH) in the DoH&FW, GoI, New Delhi by **31st July** every year for further action.

Note:

- If it is not possible for annual audited accounts to be approved by the Governing Body of the state SCOVA, these may be submitted to the Financial Management Group and head of concerned state division, DoH&FW by 31st July without approval. Intimation about the approval of the Governing Body on audited accounts shall be sent to DoH&FW latest by 31st August.
- This procedure shall only be adhered to as an exception to the prescribed procedure.
- The auditors are expected to provide a management letter addressed to the Governing Body, state/UT SCOVA, wherein observations (other than those which in his opinion materially affect his opinion on the financial statements) in respect weaknesses in the systems, procedures, internal controls and checks, physical achievements, etc.
- The audited statements have to be submitted in triplicate addressed to the Director (RCH-Finance), Department of Family Welfare, Nirman Bhawan, New Delhi-110 011. Report should also contain on the face of it full

name, address, phone/fax numbers, e-mail address and mobile number etc. of the concerned officials and of the Financial Consultant engaged in the implementation of RCH Program Phase II.

- There shall be a consolidated audit of the accounts of SCOVA and district RCH societies. Audit for the year will include all the components of the RCH, Immunization Strengthening Project (inclusive of Pulse Polio Immunization), and European Commission supported Sector Investment Program (EC-SIP). The concerned auditor will specifically mention in the audit report about the coverage of audit on these components and will also ensure that the releases and expenditures are duly separately reflected in the program financial statements.

Superimposed Audit

5.20 The accounts of each SCOVA society along with its district societies shall also be subject to audit by the Comptroller and Auditor General of India as per the "CAG (Duties, Powers & Service Conditions Act 1971)". The Act also provides for a special audit/ performance audit of SCOVA societies by the team of auditors of the CAG which can be undertaken as and when found necessary.

5.21 This audit will be at the discretion of the C&AG and its AG offices and will not be a pre-requisite for submitting the audited statements to the MoH&FW, GoI.

Management Audit by MoH&FW, GoI

5.22 The Financial Management Group (FMG) at DoH&FW and any other agency appointed for the purpose may undertake the Management Audit of state SCOVAs and district RCH societies to improve the efficiency and effectiveness of the financial system. The following areas would be commented upon by the management audit:

- Management structures, policies and practices
- Rate of activity delivery - Financial/Physical
- Fixed assets management system
- Budgeting practices
- Program evaluation
- Examining the expenditure statements against approved budget provision be monitored on six monthly basis by analyzing quarterly and six monthly expenditure and physical progress reports
- The receipt of funds from DoH&FW and its subsequent releases to district and sub-district level may be monitored on half yearly basis by examining the financial report received from state SCOVAs
- Augmentation of state program management unit and district PM units can be analyzed from the reports about staff position required to be sent in the prescribed format by state SCOVAs along with financial report and physical progress reports
- By deputing senior officers of the concerned state division located at DoH&FW, to the state SCOVAs and some RCH districts
- Whether good governance practices are followed.

Compliance of Audit Observations and Providing Complete Facility for Auditing

5.23 All the state SCOVAs and their district program management units, along with CHCs/PHCs and other RCH Program implementing agencies shall be under legal obligation to provide all facilities including production of books of accounts, prescribed registers, files regarding purchases of all types of goods/items, files of construction works etc. These shall be handed over to the in-charge of audit party of any agency as mentioned in the beginning of this chapter and receipt of such record obtained on plain paper which shall be returned back to the in-charge of audit party when such records are given back.

5.24 All the above noted Program Implementation Agencies shall also be responsible to make compliance of audit observations, made in any inspection/audit report within the time limit prescribed by the controlling authority.

5.25 It will be the responsibility of the Executive Director/Project Director/State Finance Manager of the SCOVA to send an **Action Taken Note** on the audit observations of all types of audits to the FMG, MoH&FW, GoI within 6 months of the completion of a particular audit.

5.26 **The auditors will also comment on the status of the settlement of old audit paras in their audit report.**

6

Financial Management, Internal Control & Accounting System at SCOVA & District Health/RCH Societies

Guiding Principles of Financial Management

6.1 Any officer of a state SCOVA or of a district FW/RCH/Health Society, who is authorized to incur expenditure or draws money out of the RCH Phase II funds (Bank Account) for disbursement, should treat himself as a trustee of the funds of such society or district unit and would therefore, manage all types of financial affairs in the capacity of a sincere Executive Trustee.

6.2 The officer, who is authorized to draw and incur expenditure out of a state SCOVA or a District FW/RCH/Health society fund, is expected to exercise same vigilance, which a man of ordinary prudence exercises while incurring his own money. He should keep in mind that:

- Funds should not be drawn if they are not required for immediate disbursement.
- The expenditure on any item/work/article etc. should be incurred according to the approved work plan & budget provision.
- Funds should not be utilized directly or indirectly on himself or on any family member or relative of the officers who operate the funds of the society or a unit for the time being.
- The Executive Director at state SCOVA and district RCH Program Officer at District FW/RCH/Health Society level will ensure, with the help and assistance of Consultant (Finance) & Accounts Executive, respectively, that an efficient system of internal financial control is introduced, for which they should visit district FW/RCH/Health Society & RCH Program implementing agencies

frequently & make instant inspections/examinations of cash book, bank pass book, ledgers & some vouchers of more than Rs.1,000/- value and satisfy themselves that all of these are being maintained properly.

- Officers authorized to incur expenditure must ensure that financial order and strict economy are enforced at every step and see that all relevant financial rules, orders, directions and instructions are observed.
- It should be seen that not only the total expenditure is kept within the limits of the budget provision but also that the funds allotted/transferred, are spent strictly in the interest and service of the program and upon the objects for which provisions have been sanctioned.
- He will also see that items of expenditure are of obvious necessity and are at fair and reasonable rates, sanction of the competent authority obtained and calculations are correct.
- In order to exercise proper financial control, he should keep himself closely acquainted with the progress of receipts, expenditure, commitments or liabilities incurred but not paid.

Cautions Before Withdrawal & Disbursement of Funds

6.3 Money from the society's fund should be drawn only when it is required for immediate payment/ disbursement to any party or person or firm. It shall always be paid through account payee cheques/demand draft.

6.4 Before authenticating a cheque for any payment/disbursement, the cheque drawing officer, in this regard, shall ensure that:

- There is a proper and formal statement of claim (Bill) or invoice through which payments have been demanded by the concerned person or party or firm.
- That the purchases made or services received are according to the approved plan and the claimant is entitled to get it.
- That the particulars of the claim (i.e. rates, calculations, net payable amount etc.) have been examined/checked by the computer accountant or by an authorized accounts person and have also been entered in appropriate stock/store register wherever necessary and certification on this account has been made on the bill/claim itself by an authorized officer.
- A competent sanction to incur expenditure is attached with the claim. In case of petty payments signing of a cheque on the basis of a voucher shall tantamount to be a competent sanction for payment, provided that on the voucher concerned "Passed and Authenticated for Payment" orders have been mentioned signed by one of the cheque drawing officer.

Procedure for Utilization of Funds

6.5
- The society funds shall be drawn through cheques and/or bank drafts.
- All cheques shall be signed by two signatories of the finance and administration division, authorized by the Governing/Executive body of the society, on the basis of a written authorization from the concerned program manager/consultant and/or head of concerned Division and/or Executive Director and/or Director Health Services.

- Wherever releases are decided to be made through bank drafts, the authorization letter to the bank shall be signed by the concerned authorized signatories.
- In case electronic banking (e-Banking) is introduced by the Government of India for fund release and day-to-day payments for program implementation, separate detailed guidelines will be issued by the Government of India for effecting fund transfer and execution of payments.
- In all cases where funds are to be released on the basis of approved plans, the concerned program manager shall prepare a 'request for release' proposal for issue of cheque/draft by the Finance and Administration Division. The 'request for release' shall be routed to the Finance and Administration Division through the concerned Head of Division and shall be accompanied by (a) a copy of the agenda papers of the relevant meeting of the Governing Body/Executive Body and (a) a copy of the minutes of the relevant meeting indicating approval of the proposals.
- In all other cases, proposals shall be initiated by the concerned Division and sent to Finance and Administration Division after obtaining the approval of the appropriate authority, depending on the sum involved.

Operation of Saving Bank Account

6.6 In all state SCOVAs and district societies, the operation of the savings bank account would be permissible only with joint signatures as per following norms:

- At state SCOVA level; the Executive Director & state RCH Program Officer or any two officials authorized by the Executive Committee of the State Society. In the absence of any one above noted officer, Consultant (Finance) may be authorized, if found appropriate, to sign the letters of authority to transfer funds to a district health/RCH society based on the well set norms.
- At district health/RCH Society level; Chief Medical & Health Officer and District RCH Program Officer or any two officials authorized by the Executive Committee of the District Society.

Note:

In case of payment of an amount more then Rupees two lakhs at a time to a firm or party or person, approval from the Chairperson of the Executive Committee of the state SCOVA and Chair-person of the Governing Body of the District Health/RCH Society, shall be obtained on the file, before cheques are singed by the authorized signatories.

6.7 In view of above, separate books of accounts and prescribed registers shall be maintained for each saving bank account in the formats enclosed with the manual. Similarly books of accounts of a particular financial year should be closed at its end and a new set of books and registers should be opened/started with effect from 1st April every year.

Treatment of Interest Earned in the Bank Account

6.8 Interest earned on the grants-in-aid received and deposited in the bank account can be utilized for the purpose for which grant was received provided the same is properly reflected in the books of account. This also should be appropriately shown in the utilization certificates and the audited annual accounts separately.

6.9 **The expenditure out of the interest earned will also be subjected to the same administrative and financial approvals as the main grant.**

Preparation of Cheques

6.10
- All the cheques shall be entered in the prescribed register before they are submitted for signatures, indicating its number, amount, name of the person or party, purpose and date of issue.
- Cheque books, new or used or under used shall be kept in the personal custody of one of the officer who are authorized to put their signature on the cheques.
- Acknowledgement of a cheque shall be obtained from the payee (receiver) in the prescribed format.
- Dated signatures shall be obtained in the cheque issue register from the cashier/accountant for each cheque, which is endorsed in his favor or handed over to him for obtaining cash payment from the bank.
- All persons handling cash and keeping valuable stores should be required to provide Fidelity Guarantee Bond in favor of the state SCOVA of not less than Rs.50,000/- from a nationalized insurance company or bank against which monthly security allowance will be paid on the basis of 1% of the 'Fidelity Guarantee Bond' value per month.

Writing of Cash Book

6.11
- All payments which are received in the state SCOVA or in a district Health/RCH Society, either in cash or through cheques/bank drafts/money orders/bankers cheque etc. shall be first entered in the prescribed register and then entries in the Cash Book shall be made, on the same day. Likewise all payments/disbursements shall be entered in the cash book on the day of the payment.
- Vouchers for each receipt and payment shall correctly be prepared by the writer of the Cash Book in the prescribed format, and checked by the computer accountant.
- Receipts shall be issued, for the cash/bank drafts/banker cheque and money orders on its entry in the prescribed register, signed either by one of the fund operator or by an authorized officer.
- Cash Book shall be written on daily basis and closed on the same day at 4 PM and put up for checking & authentication to one of the cheque signing officer as decided by the chairperson of the Executive Committee of a SCOVA or district health/RCH society.
- Totals of the Cash Book should be got checked by the Data Manager or by any other person other than the writer of the cash book, and a certificate to this effect shall be recorded at the end of each page with dated signatures of any one of the cheque singing authorities or by an authorized officer.
- Heavy cash balance, more than Rs.5,000/-, should not be kept in office, as far as possible.
- In case of any emergency, cash balance in the custody of the cashier, should be permitted to be kept to the extent of his/her security amount mentioned in the fidelity guarantee bond.
- Peons/messengers or temporary employees should not be engaged or authorized to obtain cash from the bank. Escort should be provided to the cashier when he is required to carry the amount more than Rs.10,000/- from the bank at a time. If possible the cashier should be provided vehicle to obtain heavy cash form the bank.

- The Cash Book is the principal record of all money transactions taken place every day and all other registers are subsidiary. It should be maintained on the basis of double entry system as per format appended with the manual.
- Each entry of receipt and expenditure should be descriptive but brief in nature. Each voucher should be assigned a serial number and ledger folio number, which should be noted against each entry in the Cash Book.
- Cash Book should be closed daily and if no transactions have taken place in a day/s the entry **"No Transaction"** has to be noted in the cash book on that day/s in red ink and balances are to be carried over to next day.
- All cash/cheques/demand drafts etc. received should be deposited into bank as far as possible on the same day it self, otherwise on the next day positively. If any cash remains in office on any day it should be kept in the cash chest/vault which should have double lock system. The cash kept in the chest should be deposited in the bank account on the next day and the entry in the cash book should be verified physically by the authorized officer. A 'double lock register' will be maintained in the format enclosed with the manual. One key of the cash chest should be kept by the cashier and another by the authorized officer.
- Over-writing should be avoided and corrections, if any, should be attested by the authorized officer under his dated initials.
- Account payee cheques should only be issued to third parties/firms etc. and the issue of bearer cheques should be avoided as far as possible.
- While making payments through cheque, its number should invariably be noted in the Cash Book for cross checking.
- Format of cash book to be maintained at state SCOVA and district RCH societies is at **Appendix-7**.

Verification of Cash Balance

6.12 The contents of the cash chest/cash box should be counted by the Consultant (Finance) at SCOVA and RCH Program Officer at health/RCH society level at least once in a month at the close of the month or on the first day (immediately after opening of office) of the next month and the amount will be compared with the cash book balance shown in the Cash Book.

6.13 The result of verification should be recorded in the cash book each time as under.

6.14 A cash balance certificate shall be obtained at the end of each year as per the format provided in appendix. In case the cash balance is found to be less or in excess then the balance shown in the cash book, the fact should be recorded in the cash book and a formal report should also be submitted to the next higher authority for further necessary action.

Maintaining Books of Account

6.15 Complete and correct accounts in respect of each monetary transaction occurring at state SCOVAs or at district RCH societies shall be maintained through prescribed books of account including registers as indicated below:

- Cash book with cash & bank columns based on mercantile system.
- Petty Cash Book

- Cheque issue register
- Register of money orders and bank drafts received
- Bank pass book
- Register of bank drafts dispatched.
- Ledger
- District program management unit-wise ledgers at State/UT SCOVAs (Control Account)
- Journal
- Registers for temporary advances as below
  - Advance to the staff (control account)
  - Advances to the contractors/suppliers/CHCs/PHCs(control account)
  - TA/DA advance (Control Account)
- Register for staff payments
- Stock Registers for:
  - Civil Works
  - Machinery & Equipment
  - Furniture & other non-consumable articles
  - Register for drugs & medicines
  - Register of consumable articles
- Register of advances to NGOs and other voluntary agencies implementing RCH II Program
- Register of investments
- Dispatch register
- Office attendance register
- File register

Notes: Any other book of accounts and resisters, which may be considered necessary for the day-to-day work of the state SCOVA, the health/RCH society shall maintain the same with the approval of the Consultant (Finance) at SCOVA and RCH Program Officer at district health/RCH society level.

6.16 The name of the district should be indicated against each entry in the cash book, till the accounts are not computerized, for the purpose of preparation of district wise accounts. At the end of the month, the district wise abstract should be prepared showing monthly disbursement in respect of each district.

6.17 The state SCOVA and its district health/RCH society shall maintain dead stock registers, separately for machinery & equipment's and other non-consumable articles and shall also arrange for physical verification of stores articles of permanent or long duration nature, at least once a year in the month of April. If any item of permanent nature is purchased at CHC/PHC level, entry in the concerned register of district RCH society shall be made on the basis of the voucher or bill etc.

6.18 All functionaries should ensure that only actual expenditure incurred is treated as expenditure and not the normative costs in accounting. Therefore, fund released by the state SCOVA to District RCH Societies or to any other implementing agency by the district RCH society such as CHC/PHC etc. shall initially be classified as advance and the same is indicated as such in the books of accounts. The advances shall be adjusted based on the expenditure statement/utilization certificate received from the advancee. Advance, if not actually spent or if spent but accounts not settled should be shown as advance and not as expenditure and all such outstanding/unsettled advances should be shown in the SoEs separately.

6.19 Advances to hospitals/PHC/CHC, etc. up to Rs. 5000 (Rs. five thousand only) will be treated as expenditure for the purpose of reporting the expenditure in the financial reports. However, for all advances, including advances up to Rs.5000, societies will maintain a separate advance register in the format given at **Appendix-10** and track the advances in the format given at **Appendix-11.**

6.20 The audit will verify the status of settlement of all advances.

Codification of Expenditure/Account Heads

6.21 For the sake of uniformity in booking of the expenditure under a specific head of account, a list showing account heads is enclosed with this manual as **Appendix -3**. All the state SCOVAs and their district RCH societies are required to follow the suggested heads of account and book the expenses accordingly in cash book & ledgers irrespective of the fact whether the accounts are maintained on hand written basis or in computers.

MIS-Classification of Expenditure

6.22 If any item of receipt or payment (cheque), belongs to one head of account has been wrongly classified under different head, the error can be corrected by making an adjustment entry in the journal and posting of the same in the related ledger account heads. It should be noted that such corrections in the cash book or ledgers can be made before the accounts of a financial year are closed to prepare annual accounts for audit purposes.

Journal

6.23 Journal is one of the most important account books but its use is restricted to recording adjustment entries only other than cash transactions. Vouchers shall support each adjustment entry passed through a journal. Brief narration of each entry shall be given in the voucher and it should be signed by the cheque drawing officer. The Associate Consultant (Accounts) at SCOVA and Accounts Executive at Health/RCH Society will check each such entry of the journal with the journal voucher and other subsidiary vouchers and put dated initials against the entries checked.

Ledger

6.24 The ledger is also an important register in which all transactions recorded in the cash book or journal are classified under different heads of accounts as codified and shown in **Appendix-8** which is applicable to both state SCOVA and district RCH societies.

6.25 The ledger should be kept in the prescribed form. Separate pages need to be opened for each item of expenditure. The ledger accounts shall be arranged and grouped in such a manner that the desired information is promptly secured.

6.26 Combined ledger accounts can be maintained for various detail heads. The contingent register can be maintained in such a manner that it is used as ledger for recording expenditure under miscellaneous items.

6.27 Every ledger account is divided into two sides, the left hand side being the "debit side" and the right hand side the "credit side". All items of debits and credits of the cash book and journal shall, invariably be posted on the same day in respective ledger accounts. Daily totals should be made, shown in the inner column and the progressive totals shown, wherever necessary in the outer (balance) column.

6.28 All the ledger accounts shall be closed at the end of the month. Totals would also be made in the classified abstract. Monthly totals of various ledger accounts shall then be tallied with the totals of classified abstract and discrepancy, if any, will be rectified and reconciled.

6.29 Bank account shall be posted from the daily totals of cheques issued and challenges/remittances (deposited) made into the bank.

Receipt and Payment Statement

6.30 Monthly account of receipts and payments shall be prepared immediately after closing of the accounts for the month but not later then 5th of the next month.

Bank Reconciliation Statement

6.31 Bank reconciliation statement will be prepared on monthly basis by reconciling the cash book and bank pass book/bank statement by 10th day of the following month. Bank pass book will be sent to the bank on weekly basis for making up-to-date entries of credits and debits in the month. Any discrepancy will be rectified and difference explained in the bank reconciliation statement as per the format provided in the **Appendix-9.**

Advance Register

6.32 All advances sanctioned to an officer of state SCOVA or to the District Program Management Unit or to the in-charge Medical Officer of a CHC or PHC or to any other official of the above institutions and also to any non-government organization, shall be entered in the advance register (format given in **Appendix-10)** immediately after the advance amount/ cheque is given to the advancee. For the purpose of reporting to the MoH&FW, GoI by way of quarterly statement of expenditure, the advances up to the amount of Rs.5,000/- given by the District RCH Societies may be treated as expenditures. Any advance remaining unadjusted at the year end may be adjusted in the SoE for the last quarter of the year. However, the procedure for adjustment/settlement/refund of advances and their depiction in the advance register may continue as prescribed. The audit by Chartered Accountant would ensure the compliance and also highlight the advances pending adjustment for long period. For the purpose of facilitating proper tracking of advances and their settlement, an Advance Tracking Register should be maintained, at all the levels from where the advances are given, in the format given at **Appendix-11.**

Register of Fixed Assets

6.33 Each SCOVA and its district societies shall maintain stock registers for the articles or item of permanent or of non-consumable nature indicating the details of such assets e.g. furniture, fixtures, equipment's, machinery, instruments, vehicles, computer systems etc. purchased during the program

period. Such register is also called as register of permanent (nature) articles or "dead stock register." Annual physical verification shall be carried out in the month of April every year. This register shall be maintained in the format given in **Appendix-12.**

6.34 Only those articles, as mentioned in the above para, will be treated as assets of the society which are procured, used and installed in the Office of the Society and will form part of the core asset of the society. Formal tracking as per the requirements of the asset register for the entire life of the asset will be done by the society.

6.35 All other assets which are purchased by the society and subsequently handed over to the Office of Health & Family Welfare/Family Welfare Stores/CMOs/PHCs/CHCs, etc. will be shown as transferred to such entities in the asset register and no further tracking about the life of the asset will be required. However, a certificate from the receiving entity will be required to be kept in the asset register with contra entry in the 'location/under custody' column of the asset register **(Appendix-12).**

Re-Appropriation of Funds

6.36 Any changes in the approved AWP may be discussed during the quarterly and annual reviews and implemented by mutual consent. The states/UTs may amend their approved AWP within 10% of any of the sub item(s) so as to have flexibility in inter-component use of funds without affecting the overall outlay approved for the state/UT for the year. Activity-wise performance evaluation will then be synchronized with the revised work plan. In all such cases FMG, GoI will necessarily be informed of this revision.

Computerisation of Accounts

6.37 It is desirable that maintenance of accounts at the state/UT SCOVAs as well as at district RCH societies is computerized so that the account statements can be prepared accurately and promptly with least efforts and time. Currently, a number of readymade accounting software packages are available in the market like Tally, Target, EX, etc. The state may examine these for introducing them for RCH accounts depending upon their availability and after sale service and decide appropriately.

Appendix-A

Model Delegation of Financial and Administrative Powers for Smooth and Efficient Working of the State H&FW/RCH Society/ SCOVA

1. Classification of items of expenditure and financial powers of the bodies and office bearers of the society :

Type of expenditure	Authority	Extent of power
A: Approval of district/ city plans.	Governing Body / Executive Body	Full powers, provided that the plan(s) have been endorsed by a Project Appraisal Committee comprising of technical and non-technical officers of the Society / Directorate.
B: Release of funds for implementation of plans / allocations approved by Governing Body / Executive Body.	Executive Director / Director (Health Services/FW) / Executive Secretary	Full powers.
C: Expenditure proposals not covered under categories A and/or B		
C-1: Procurement of goods C-2: Repairs and minor civil works	Chairperson, Executive Committee	More than Rs 5.00 lakh and upto Rs. 10.00 lakh per case.
C-3: Procurement of services for specific tasks including outsourcing of support services for the Directorate of Health Service.	Executive Director / Director (Health Services/FW) / Executive Secretary	Upto Rs. 5.00 lakh per case.
C-4: Hiring of contractual staff, including sanction of compensation package.	Chairperson, Executive Committee / Executive Director / Director (Health Services/FW)	Full powers, provided that the contracts shall be for a period not exceeding 11 months at a time.

Contd....

Type of expenditure	Authority	Extent of power
	Executive Secretary / Division Heads	Full powers in respect of Clerical / Class-IV equivalent positions, subject to compensation package approved by the Governing Body, provided that the contracts shall be for a period not exceeding 11 months at a time.
C-5: Miscellaneous items not mentioned above such as hiring of taxis, hiring of auditors, payments relating to documentation and other day-to-day services, meetings and workshops, training, purchase of training material/ books and magazines, payment of TA/ DA and honoraria to resource persons and guest speakers invited to meetings/ workshops, and payment of TA/DA allowances for contractual staff and/or non-official invitees to Governing Body / Executive Committee meetings and/or Government / Society staff deputed to meetings outside the state.	Chairperson, Executive Committee	Upto Rs. 5.00 lakh at a time subject to a maximum of Rs. 50 lakh per annum.
	Executive Secretary / Executive Director / Director (Health Services /FW)	Upto Rs. 2.00 lakh at a time, subject to a maximum of Rs. 25.00 lakh per annum.
	Division Heads	Upto Rs. 20,000/- at a time subject to a maximum of Rs. 2.00 lakh per annum.

2. Project Appraisal Committee:

- The society shall have a Project Appraisal Committee (PAC) to consider the district / city plans and expenditure proposals falling in categories C-1 to C-3. The PAC shall consist of senior program managers drawn from the various program divisions and headed by any one of the Additional Directors as may be jointly agreed between Executive Director and Director Health Services.
- Proposals under categories C-1 to C-3 will be submitted to the concerned authority having delegated powers provided hereinabove for final approval. In case the designated authority does not agree with the recommendations of the PAC, s/he shall record the reasons for such disagreement and may include the proposal in the full meeting of the Executive Committee / Governing Body which shall have the full powers to accept / reject the recommendations of the PAC provided that the reasons for rejecting the PAC recommendations shall be recorded in the minutes of the Executive Committee / Governing Body.

Appendix-B

Model Delegation of Financial and Administrative Powers for Smooth and Efficient Working of the District H&FW/RCH Society

Model Delegation of Financial & Administrative Powers for Smooth and Efficient Working of the District Health/FW/RCH Societies

Type of expenditure	Authority	Extent of power
A: Release of funds to Hospitals/ hospital societies, block Medical Officers and other implementing agencies as per State Government approved norms and/or proposals approved by State Government. B: Release of funds for implementation of plans/allocations approved by Governing Body/Executive Committee.	Executive Secretary / Member-Secretary of the concerned Programme Committee	Full powers.
C: Expenditure proposals not covered under categories A and/or B		
C-1: Procurement of goods. C-2: Repairs and minor civil works. C-3: Procurement of services for specific tasks including outsourcing of support services.	Chair-person, Governing Body	More than Rs 2.00 lakh and upto Rs. 5.00 lakh per case.
	Chair-person, Executive Committee	Upto Rs. 2.00 lakh per case.
C-4: Miscellaneous items not mentioned above such as hiring of taxis, hiring of auditors, meetings and workshops, training, purchase of training material/ books and magazines, payment of TA/ DA allowances for contractual staff and/or non-official invitees to DHS meetings and/or officials deputed to meetings outside the district.	Chair-person, Governing Body	Upto Rs. 1.00 lakh at a time subject to a maximum of Rs. 10 lakh per annum.
	Chair-person, Executive Committee	Upto Rs. 50,000 at a time, subject to a maximum of Rs. 5.00 lakh per annum.
	Member-Secretaries of the Programme Committees	Upto Rs. 5,000 at a time subject to a maximum of Rs. 1.00 lakh per annum.

Note:

- During the Financial year, no authority can exercise the powers beyond the amount provided against that item in the annual work plan and budget for that financial year approved by the GOI.
- A higher authority in the District Health & Family Welfare Society may exercise the power delegated to the authority subordinate to it.
- No appointment in District Health & Family Welfare Society will be made by any authority except on the recommendation of the selection committee duly constituted by Chairperson.
- Every cheque will be signed by two functionaries of District Health & Family Welfare Society.
- Purchases under C-1 will be made through a duly constituted purchase committee with the approval of Chairperson of the Governing Body of the District Health/Family Welfare Society.

Appendix-C

Terms of Reference and Requisite Qualifications for the Finance and Accounts Consultants in the State and District Health/RCH Societies

State Level

S. No.	Name of the position	Terms of reference and qualification
1.	**Manager (Finance)**	■ To aid, advise and assist the Director (H/FW)/Standing Committee of Voluntary Action (SCOVA)/Health & Family Welfare Department in proper flow of funds and in all aspects of financial matters. ■ To ensure maintenance of accounts as per the finance & accounts manual for SCOVAs and District RCH/Health Societies, GoI and World Bank. ■ To assist in all disbursements required under the program to ensure timely submission of statement of expenditure. S/he must establish and adequate internal control system to safeguard all project resources. ■ To assist the State's department of Health and Family Welfare/SCOVA in monitoring the expenditure and assessing the requirements of funds; prepare budget estimates and proposals for release of funds. ■ To conduct budget analysis for health sector and develop proposals for improving financial management systems. ■ To develop operational manuals for management of funds in the states, districts and facility level societies and coordinate annual audits. ■ To oversee financial management in the districts and to ensure financial progress as per plans. ■ To assist the State Department of Health/Family Welfare/SCOVA in the implementation and thereafter in operation of e-banking initiative with regard to grant release and expenditure monitoring. ■ Ensuring timely issue and submission of Utilization Certificate for the utilised funds (as per Form No. GFR-19A given in Appendix-6 of this manual). **Qualifications** The ideal candidate will be a CA/MBA(Finance)/ICWA/MFC/CFA. High level of proficiency in application of accounting software packages is essential.

Contd....

S. No.	Name of the position	Terms of reference and qualification
2.	**Accounts Manager**	■ To maintain the records of the society accounts. ■ To facilitate disbursement of funds to implementing agencies. ■ To prepare SoEs and arrange audits as per the finance & accounts manual for SCOVA and District RCH/Health Societies and society byelaws. ■ To assist Manager Finance in ensuring financial progress among implementing agencies as per plans. ■ To assist the State Department of Health/Family Welfare/SCOVA in the implementation and thereafter in operation of e-banking initiative with regard to grant release and expenditure monitoring. ■ Implementing computerised financial MIS. ■ Ensuring timely issue and submission of Utilization Certificate to GoI for the utilised funds (as per Form No. GFR-19A given in Appendix-6 of this manual). **Qualifications** The ideal candidate will have an Inter-CA/Inter-ICWA/M.Com. degree. Working knowledge and experience of popular accounting software packages is essential.

District Level

S. No.	Name of the position	Terms of reference and qualification
1.	**District Accounts Manager**	■ Managing the accounts of the society. ■ Disbursement of funds to the implementation agencies. ■ Preparation and submission of monthly/quarterly/annual statement of expenditures (SoEs) in the prescribed format. ■ Ensuring adherence to laid down accounting standards. ■ Adherence to system for periodic internal and external audits and established accounting systems. ■ Implementing computerised financial MIS. ■ To assist the District RCH/Health Society in the implementation and thereafter in operation of e-banking initiative with regard to grant release and expenditure monitoring. ■ To assist District Program Manager in budgeting and planning for program implementation. **Qualifications** The ideal candidate will be a CA/MBA(Finance)/ICWA/ MFC/ CFA. High level of proficiency in application of accounting software packages is essential.

Appendix-1

Budget Receipt & Control Register for *'Name of the State/District'* For the Financial Year Ending_____

(Amount in Rupees)

Date	Activity/ Particulars	Approved Budget (A)	Grants-in-Aid received (B)				Total Budget received (C= A+B)	Balance budget (D=A-C)	Funds Released to the Districts/ Spent	Unspent Funds Available
			1st Receipt	2nd Receipt	3rd Receipt					

Appendix-2

Financial Management Indicators

- To be sent twice during 2005-06 - on 30th Sept. and 31st March.
- To be sent only once on 31st March in the subsequent years.

(Name of the State: _____)

A. Finance HRD Related Indicators

A.1. Qualified and Skilled Finance and Accounts Manpower in Place

	No. of skilled Finance / Accounts personnel	If no skilled finance / accounts staff is in place, who is handling the job?
At State SCOVA		

A.2. Vacancy Position of the Finance and Accounts Staff

	No. of Sanctioned Posts	No. of Staff in position	No. of Vacancies	Since when Vacant *(Give date)*	Reason for Vacancy	Action Plan & time frame for filling up the vacancy
State level						
District level *(total for all the Districts put together)*						

A.2.1 District-wise Details *(attach separately in this format)*

S. No.	Name of the District	No. of Sanctioned Posts	No. of Staff in position	No. of Vacancy	Since when Vacant *(Give date)*	Reason for Vacancy	Action Plan & time frame for filling up the vacancy
1							
2							
3							
..							

A.3. Integration and Empowerment of Finance / Accounts Personnel into the System

		Yes (please tick) (give date on which done)	**No** (please tick)	If **'No'**, please specify by when expected
1.	Org. structures of State and district level finance & accounts staff submitted to GoI			
2.	GO issued specifying duties and channel of reporting.			

A.4. Training of Finance Personnel Completed

		Yes (please tick) (give date on which done)	**No** (please tick)	If **'No'**, please specify by when expected
1.	State level finance and accounts staff trained by GoI			
2.	District level finance and accounts staff trained by state government.			

A.5. Dotted line relationship with the FMG, GoI - *(this information needs to be sent only once every year on 31st July along with Audited Statements and UCs)*

		Yes (please tick) (give date on which done)	**No** (please tick)	If **'No'**, please specify by when expected
1.	Performance of contractual finance and accounts staff evaluated on yearly basis and evaluation sheet forwarded to FMG, DoH&FW, GoI.			
2.	Concurrence of central FMG taken for yearly extension of tenure of finance and accounts staff.			

B. Financial Empowerment Related Indicators

B.1. Delegation of Adequate Financial and Administrative Powers

		Yes (please tick) (give date on which done)	**No** (please tick)	If **'No'**, please specify by when expected
1.	Govt. Order (GO) or resolution of SCOVA delegating the financial and administrative powers to functionaries of SCOVA and district RCH societies submitted to GoI			
2.	At state level adequate powers delegated to the ED/Project Director			
3.	At district level adequate powers delegated to the CMO			
4.	At PHC/CHC levels, retention and powers delegated for use of user charges collected there			

B.2. Adequate Infrastructure Facilities like Computers, Printers, Telephone, Fax, Internet Connection, etc. Provided to Finance and Accounts Staff

			Yes (please specify items provided)	No (please specify items not provided)	When are the items listed in the **'No'** column expected to be provided?
1.	**At State SCOVA**				
2.	**At District Health/RCH Societies** *(Give district-wise details):*				
	1.	(Name of the District)			
	2.	,,			
	3.	,,			
	..	,,			

C. Financial Performance Related Indicators

C.1. Financial Reports (in the format prescribed at Appendix-5)

Quarterly						
Timely *(within a month after the end of quarter)*	**Delay of 1 month**	**Delay of 2 months**	**Delay over 2 months**	**No. of Districts omitted**	**Quality of financial reports**	**Action taken to overcome delays in future**

C.2. Audited Statement of Accounts & Audit Reports

Annual							
Timely by 31st July	**Delay of 1 month**	**Delay of 2 months**	**Delay over 2 months**	**No. of districts omitted**	**Quality of audit reports**	**No. of audit observations**	**Action taken to overcome delays in future**

C.3. Utilization Certificates

Annual					
Timely, along with audited statements of accounts by 31st July	**Delay of 1 month**	**Delay of 2 months**	**Delay over 2 months**	**Quality of UCs submitted**	**Action taken to overcome delays in future**

Place: (signed by)

Date: (Executive Director/ Project Director State SCOVA)

(With seal of office)

Appendix-3

Reproductive & Child Health Program, Phase II
Names of Account Head for Booking of Expenditure

A.	Technical Strategies & Activities
A.1	**Maternal Health**
A.1.1	Contractual Staff and Services:
A.1.1.1	■ ANMs
A.1.1.2	■ Laboratory Technicians
A.1.1.3	■ Staff nurses
A.1.1.4	■ Doctors (SM Consultants, Anaesthetists, etc.)
A.1.2	Other MH Interventions:
A.1.2.1	Operationalization of FRUs (Infr., equipment, furniture, etc.)
A.1.2.2	24 Hour Delivery Services (at PHCs)
A.1.2.3	RTI/STI Services
A.1.2.4	Dai Training
A.1.2.5	Referral Transport
A.1.2.6	RCH Camps
A.1.2.7	Others (Please specify)
A.1.3	NMBS (Janani Suraksha Yojana):
A.1.3.1	■ Payment to Beneficiaries
A.1.3.2	■ Payment to ASHA/Dais
A.1.3.3	■ Payment for Referral Transport
A.1.3.4	■ Payment for Caesarian Section
A.2	**Child Health**
A.2.1	Immunization
A.2.1.1	Vaccines for Routine Immunization
A.2.1.2	Hepatitis Vaccine
A.2.1.3	Needles and Syringes
A.2.1.4	Neo-natal Equipment

Contd....

A.2.1.5	Cold Chain Equipment
A.2.1.6	*RI strengthening project*
A.2.1.7	Cold Chain Maintenance
A.2.1.9	Pulse Polio Operating Costs
A.2.2	Essential Newborn Care
A.2.5.1	IMNCI (Mainly Training)
A.2.5.2	Others (may be specified)
A.3	**Family Planning Services**
A.3.1	Sterilization
A.3.1.1	Compensation for Sterilizations
A.3.1.2	Others (may be specified)
A.3.2	Miscellaneous Expenses (FP): *(as per PIP)*
A.3.2.1	Cu T 380 A' Camps
A.3.2.2	Procurement of Laproscopes/Laprocators
A.1.4	Others (may be specified)
A.4	**New Initiatives/Innovations/Interventions etc., if any**
A.4.1	PNDT
A.4.2	Community Incentive Scheme
A.4.3	Transportation of Supplies/Contraceptives
A.4.4	Public-Private Partnerships
A.4.5	MNGO Expenses
A.4.6	Other Initiatives (may be specified)
B.	**Urban RCH**
C.	**Tribal RCH**
D.	**Institutional Strengthening**
D.1.1	Major Civil Works (New Constructions/extn./additions)
D.1.2	Minor Civil Works (Repairs & Renovations)
D.1.3	Logistics Management/Improvement
D.1.4	Others (may be specified)
E.	**Training**
F.	**Behavioural Change & Communication (BCC/IEC)**
F.1	BCC/IEC Activities
F.2	Adolescent Health
G.	**Program Management**
G.1	At State Level
G.2	At District Level

Note: The above heads have been selected on the basis of quarterly financial report to be sent by SCOVAs to the GoI (Appendix- 5)

Appendix-4

Format for Monthly Financial Report

In the district of _____

Statement of expenditure for the month of _____

S.No.	Activities/ Particulars	Opening balance (Rs.)				Receipt (Rs.)	Expenses incurred (Rs.)	Balance (Rs.)			
		Bank	Advance	Cash	Total			Bank	Advance	Cash	Total

Prepared and Checked by: Signature of Accounts Clerk

Signature of District RCH Officer

APPROVED BY: CMO/CDMO/CHMO/CS

Notes:

1. The SoE should be submitted by the District RCH Society to State SCOVA on a monthly basis so as to reach there by 10th of the following month without fail.
2. There should be one consolidated SoE for all schemes/ activities and this should be submitted to State Division rather.
3. This SoE should be submitted for all the centrally sponsored programmes of the DoH&FW.
4. A SEPARATE column in the above shall be provided to show Budgeted/Plan Expenditure.

Appendix-5

Format of Financial Management Report to be submitted by the States/UT Health/RCH Societies to Center on Quarterly basis

Reproductive and Child Health Program, Phase - II

("Name of the State/UT") State Health/RCH Society/SCOVA

FINANCIAL REPORT FOR THE QUARTER ENDED_____ of the Financial Year _____

NOTES: (1) The total budget and expenditure against the heads may be indicated in such a way as to avoid duplication. (2) In case there are overlapping activities (i.e., expenditure may be comprising one or more component (s), it can be shown under the item where the major chunk of it has taken place. (3) Budget and expenditure under Others & Misc. expenditure may be specified in case the amounts are material (say, exceeding 3% of the total budget of the State Society). (4) Opening balance for the First Quarter of the FY 2005-06 will be the unspent amount available as on 31st March 2005 out of funds sanctioned up to 31st March 2005. (5) Reasons for major variations need to be enclosed with this FMR.

(Rupees in Lakhs)

S. No.	Activities as per State PIP/Annual Action Plan (To be regrouped in the following broad heads if listed differently)	Amount as per approved State PIP/ Annual Action Plan for FY 2005-06	Opening Balance for the Quarter (See Note-4 above)	Funds rece-ived during the Quarter	Cumu-lative Funds received during the Year	Cumulative Funds Received since the start of Program, i.e., 1-4-2005	Projected Expenditure for the Quarter as per Annual Work Plan	Actual Expe-nditure During the Quarter	Cumu-lative Expen-diture during the Year	Cumulative Expen-diture since start of the Program, i.e., 1-4-2005	Unspent Closing Balance at the end of the Quarter Col. (5) -(9)	Variance with the Projected Expenditure Col. (6) - (7) (See Note-5 above)
		1	2	3	4	5	6	7	8	9	10	11
A.	**TECHNICAL STRATEGIES & ACTIVITIES**											
A.1	**MATERNAL HEALTH**											
A.1.1	**Contractual Staff & Services:**											
A.1.1.1	- ANMs											
A.1.1.2	- Laboratory Technicians											
A.1.1.3	- Staff Nurses											
A.1.1.4	- Doctors (SM Consultants, Anaesthetists, etc.)											

Contd...

S. No.	Activities as per State PIP/Annual Action Plan (To be regrouped in the following broad heads if listed differently)	Amount as per approved State PIP/ Annual Action Plan for FY 2005-06	Opening Balance for the Quarter (See Note-4 above)	Funds received during the Quarter	Cumulative Funds received during the Year	Cumulative Funds Received since the start of Program, i.e., 1-4-2005	Projected Expenditure for the Quarter as per Annual Work Plan	Actual Expenditure During the Quarter	Cumulative Expenditure during the Year	Cumulative Expenditure since start of the Program, i.e., 1-4-2005	Unspent Closing Balance at the end of the Quarter Col. (5) - (9)	Variance with the Projected Expenditure Col. (6) - (7) (See Note-5 above)
		1	2	3	4	5	6	7	8	9	10	11
A.1.2	**Other MH Interventions:**											
A.1.2.1	Operationalization of FRUs (Infr., equipment, furniture, etc.)											
A.1.2.2	24 Hour Delivery Services (at PHCs)											
A.1.2.3	RTI/STI Services											
A.1.2.4	Dai Training											
A.1.2.5	Referral Transport											
A.1.2.6	RCH Camps											
A.1.2.7	Others (Pl. specify)											
A.1.3	**NMBS (Janani Suraksha Yojana):**											
A.1.3.1	- Payment to beneficiaries											
A.1.3.2	- Payment to ASHA/Dais											
A.1.3.3	- Payment for Referral Transport											
A.1.3.4	- Payment for Caesarian Section											
A.2	**CHILD HEALTH**											
A.2.1	**Immunization**											

Contd...

S. No.	Activities as per State PIP/Annual Action Plan (To be regrouped in the following broad heads if listed differently)	Amount as per approved State PIP/ Annual Action Plan for FY 2005-06	Opening Balance for the Quarter (See Note-4 above)	Funds received during the Quarter	Cumulative Funds received during the Year	Cumulative Funds Received since the start of Program, i.e., 1-4-2005	Projected Expenditure for the Quarter as per Annual Work Plan	Actual Expenditure During the Quarter	Cumulative Expenditure during the Year	Cumulative Expenditure since start of the Program, i.e., 1-4-2005	Unspent Closing Balance at the end of the Quarter Col. (5) - (9)	Variance with the Projected Expenditure Col. (6) - (7) (See Note-5 above)
		1	2	3	4	5	6	7	8	9	10	11
A.2.1.1	**RI strengthening project**											
A.2.1.2	Cold chain maintenance											
A.2.1.3	**Pulse Polio operating costs**											
A.2.2	**Essential New Born Care**											
A.2.2.1	IMNCI (Mainly Training. Not to be booked under 'TRAINING' at 'E' below)											
A.2.2.2	Others (may be specified)											
A.3	**FAMILY PLANNING SERVICES**											
A.3.1	**Sterilization**											
A.3.1.1	Compensation for Sterilizations											
A.3.1.2	Others (may be specified)											
A.3.2	**Miscellaneous Expenses (FP):** *(as per PIP)*											
A.3.2.1	Cu T 380 A' Camps											
A.3.2.2	Procurement/Repair of Laproscopes/Laprocators											
A.3.3	Others (may be specified)											

Contd...

S. No.	Activities as per State PIP/Annual Action Plan (To be regrouped in the following broad heads if listed differently)	Amount as per approved State PIP/ Annual Action Plan for FY 2005-06	Opening Balance for the Quarter (See Note-4 above)	Funds received during the Quarter	Cumulative Funds received during the Year	Cumulative Funds Received since the start of Program, i.e., 1-4-2005	Projected Expenditure for the Quarter as per Annual Work Plan	Actual Expenditure During the Quarter	Cumulative Expenditure during the Year	Cumulative Expenditure since start of the Program, i.e., 1-4-2005	Unspent Closing Balance at the end of the Quarter Col. (5) - (9)	Variance with the Projected Expenditure Col. (6) - (7) (See Note-5 above)
		1	2	3	4	5	6	7	8	9	10	11
A.4	**New Initiatives/ innovations/interventions etc., if any**											
A.4.1	PNDT											
A.4.2	Community Incentive Scheme											
A.4.3	Transportation of Supplies/ Contraceptives											
A.4.4	Public-Private Partnerships											
A.4.5	MNGO Expenses											
A.4.6	Other Initiatives (may be specified)											
B.	**URBAN RCH**											
C.	**TRIBAL RCH**											
D.	**INSTITUTIONAL STRENGTHENING**											
D.1.1	Major Civil Works (New Constructions/extn./additions)											

Contd...

S. No.	Activities as per State PIP/Annual Action Plan (To be regrouped in the following broad heads if listed differently)	Amount as per approved State PIP/ Annual Action Plan for FY 2005-06	Opening Balance for the Quarter (See Note-4 above)	Funds received during the Quarter	Cumulative Funds received during the Year	Cumulative Funds Received since the start of Program, i.e., 1-4-2005	Projected Expenditure for the Quarter as per Annual Work Plan	Actual Expenditure During the Quarter	Cumulative Expenditure during the Year	Cumulative Expenditure since start of the Program, i.e., 1-4-2005	Unspent Closing Balance at the end of the Quarter Col. (5) - (9)	Variance with the Projected Expenditure Col. (6) - (7) (See Note-5 above)
		1	2	3	4	5	6	7	8	9	10	11
D.1.2	Minor Civil Works (Repairs & Renovations)											
D.1.3	Logistics Management/ Improvement											
D.1.4	Others (may be specified)											
E.	**TRAINING**											
F.	**BEHAVIORAL CHANGE & COMMUNICATION (BCC/ IEC)**											
F.1	BCC/IEC Activities											
F.2	Adolescent Health											
G.	**PROGRAM MANAGEMENT**											
G.1	AT STATE LEVEL											
G.2	AT DISTRICT LEVEL											
	TOTAL											

Certified that the above amount of expenditure is duly reconciled with the amount recorded in the relevant ledger heads.

(Finance Manager/Finance Controller/ Finance Officer)

(Project Director/Executive Secretary)

Appendix-6

Form No. GFR-19A

Name of the State/State SCOVA _____

Reproductive & Child Health Program Phase II

Utilization Certificate for the Year : _____ *Dated :*

Sanction letter no. and date	Purpose	Amount
(Please give here details of Sanc. letters) 1. 2. 3.	(Selected activity under priority scheme of RCH Phase II)	(Amount of sanctions)

Certified that out of Rs. ( ) of grants-in-aids sanctioned during the financial year 2005-2006 ( ) in favor of the State SCOVA _____ by the Department of Family Welfare, Govt. of India vide letter nos. (given above) and Rs. _____ on account of unspent balance of the previous year (s), a sum of Rs. _____ has been utilized for the purpose for which it as sanctioned and that the balance of Rs. _____ remained as unutilized at the end of the year, will be adjusted towards the grants-in-aid payable during the next year.

Further certified that I have satisfied myself that the conditions, on which the grants-in-aid was sanctioned, have been duly fulfilled and that I have exercised the following checks to see that the money was actually utilized for the purpose for which it was sanctioned.

Checks exercised

Examining of

- Ledgers
- Monthly & Quarterly statements of expenditure
- Fund position reports
- Annual audited account

Signature
Name of the Chartered Accountant
Stamp of Chartered Accountancy firm
with date (Verified from annual audited accounts & found correct)

Executive Director
State SCOVA
(With Seal of Office)

Note:

(1) Unspent balance/unutilized amount of previous year plus release of funds during the year under audit are the "total funds available."

(2) Closing balance of the year means "amount remained un-utilized or not spent"

Appendix-7

Format of Cash Book

Receipt						Payment					
Date	Particulars	Party Name	Activity Head	L/f No.	Amount (Rs.)	Date	Particulars	Party Name	Activity Head	L/f No.	Amount (Rs.)
	Opening Balance b/f										
	Total Receipts						Total Payments				
							Balance c/f				
	Grand Total						**Grand Total**				

Appendix-8

Format of Ledger

Date	Particulars	Activity Head/Party Name (*)	Cash Book Folio No.	Debit (Rs.)	Credit (Rs.)	Balance (Rs.)
	Opening Balance b/f					
	Total					
	Balance c/f					

(*) 1. In case of an advance, this column would carry the name of the activity for which advance has been given.

2. In case of accounting for an expense, name of the party incurring/reporting the expense would be entered in this column.

Appendix-9

Bank Reconciliation Statement for the Month of _____

Name of the State/UT/District RCH Society: _____

Balance as per Cash Book (as on date .....) _____

Add:

(i) Cheques issued but not encashed _____

(ii) Credit entries made in the bank _____

Pass book but not shown in the cash book _____

Total _____

Less:

(i) Amount sent to Bank but not credited in the Saving Bank Account of the SCOVA or DPM Unit _____

(ii) Bank charges debited in the bank account but not accounted for in the cash book _____

Total _____

Balance as per Pass Book _____

Prepared by: Accounts Clerk/Assistant

Examined by: Consultant (Finance) Date: _____

Appendix-10

Reproductive and Child Health Program Phase II

Advance Register

Name of Officer/Official or CHC/PHC/NGO/etc. _____

Date	To whom given	Particulars of advance	Cheque no. & date	Amount	Adjustment details		Advance still out standing
					Date of adjustment	Amount adjusted	
1st Advance (on _____)							
IInd Advance (on _____)							
IIIrd Advance (on _____)							
IVth Advance (on _____)							

Notes: The above format should be depicted in two pages for the sake of facility. One or two pages should be left for SCOVA functionaries, suppliers/contractors and district PM units.

Appendix-11

Format of Advance Tracking Register

(Only under manual accounting system)

Name of the Implementation Unit/District/State/UT:

Date	Particulars	Activity			Activity			Activity		
		Advance (Rs.)	Settlement (Rs.)	Balance (Rs.)	Advance (Rs.)	Settlement (Rs.)	Balance (Rs.)	Advance (Rs.)	Settlement (Rs.)	Balance (Rs.)

Appendix-12

Format of Asset Register

Name of the State SCOVA / District RCH Society _____

Date	Voucher No.	Asset No.	Particulars	Location / Under custody of	Asset Quantity					Asset Cost				
					Qty at the beginning of the Year (1)	Addition (2)	Deletions (3)		Total Qty (1+2-3)	Cost at the beginning of the year (4) (Rs.)	Addition (5) (Rs.)	Deletions (6) (Rs.)		Total Cost (A) (4+5-6)
						New Assets	Sold / Scrap Assets	Transfer			New Assets	Sold / Scrap Assets	Transferred Out	
		Asset Code	Asset Group; Supplier Name; Asset Description; Date of Installation; Invoice No;											

Appendix-13

Guidelines for Audit

Indicative Guidelines for conducting statutory audit and management audit

A. Statutory audit

The accounts of each SCOVA and district societies will be audited by a firm of Chartered Accountants from a list provided by the Office of C&AG of India to the MoH&FW, GoI. In addition, the accounts of these societies shall also be subject to audit by the Comptroller and Auditor General of India as per the "CAG (Duties, Powers & Service Conditions Act 1971)" at its discretion. The Act also provide for a special audit/performance audit of SCOVA societies by the team of auditors of the CAG which can be under taken as and when found necessary.

B. Management audit by DoH&FW

In order to improve the efficiency of the financial system, management audit of SCOVAs and district societies will also be undertaken by the MoHFW, GoI. Under the management audit the selected outsourced firms/ officials from the Government of India, which would be deputed by the DoH&FW, would comment on:

- Management structures, policies and practices;
- Rate of activity delivery - Financial/Physical;
- Fixed assets management system;
- Budgeting practices;
- Program Evaluation;
- Whether good governance practices are followed.

Alternatively the DoH&FW may consider introducing internal financial management checks by adopting the following procedure:

- Examining the expenditure statements against approved budget provision be monitored on six monthly basis by analyzing quarterly and six monthly expenditure and physical progress reports.
- The receipt of funds from DoH&FW and its subsequent releases to districts and sub-districts level may be monitored on half yearly basis by examining the **Funds Position Reports** received from State SCOVAs.
- Augmentation of State PM Unit and district PM units can be analyzed from the reports about staff

position required to be sent in the prescribed format State SCOVAs along with six monthly expenditure/ statements and physical progress reports.

- By deputing senior officers of the concerned state division located at MoH&FW, to the state SCOVAs and one or two RCH districts.

Compliance of audit observations and providing complete facility for auditing

All the State SCOVAs and their district societies, along with CHCs/PHCs and other RCH Program implementing agencies shall be under legal obligation to provide all facilities including production of books of accounts, prescribed registers, files regarding purchases of all types of goods/items, files of construction works etc. These shall be handed over to the In-charge of audit party of any agency as mentioned in the beginning of this chapter and obtain receipt of such record on plain paper which shall be returned back to the in-charge of audit party when such records are given back.

All the above noted Program implementation agencies shall also be responsible to make compliance of audit observations, made in any inspection/audit report within the time limit prescribed by the controlling authority.

Appendix-13A

Checklist for Financial Management

Name of Society_____ Date of Visit_____ Name of Reviewer_____

S. No.	Description	Yes	No	Remarks
1.	Cash book and bank book written up to date (indicate date).			
2.	Cash balance reconciles with physical cash in hand. (Do a cash count)			
3.	General ledger is written up to date and has the relevant ledger heads (indicate date).			
4.	All vouchers are serially numbered and filed properly.			
5.	Bank reconciliation's has been done as at the end of the previous month.			
6.	Stock register for drugs, consumable and printed materials, if any, is up to date.			
7.	Fixed asset register is up to date.			
8.	Advances are classified separately and not included in the SOE. Only on the receipt of utilization certificate/contractors bill advances are adjusted and the value of work done is included in the SOE.			
9.	Are there advances outstanding for long. (greater than 6 months)			
10.	Is there a backlog in preparation of SOE, utilization certificate or audit report?			
11.	Are their any fund flow delays to district societies?			
12.	Are there any pre-signed blank cheques or large cash withdrawals.			
13.	Any other observations			

For adverse observations, what action and timeframe has been decided.

1.

2.

Note any adverse/serious findings to be reported to ———————— at the State Project Director and the FMG at the DOH&FW, GOI

Name of the reviewer & Date

Discussed and agreed with
(Name & Signature of the official of District SCOVA)

Appendix-14

List of Points to be Kept in View by the Teams of Internal/External Auditors While Conducting the Audit of State SCOVAs and District Health/RCH Societies

1. The audit activities should include pre-payment audit as well as independent appraisal of the financial, operational and control activities of the program.
2. The responsibilities of the auditor should include reporting on the adequacy of internal controls, the accuracy and propriety of transactions, the extent to which assets are accounted for and safeguarded, and the level of compliance with the RCH PhaseII financial norms and the procedures laid down in the Manual.
3. All funds have been used in accordance with the conditions laid down under relevant financial norms and regulations with due care & attention with economy and efficiency, and only on the purpose for which amount was provided.
4. Generally accepted accounting principles are being followed by all the district PM units authorized to incur expenditure under RCH Phase II.
5. Goods and services financed out of RCH-II budget have been procured in accordance with relevant provisions of the manual. Proper documents, namely purchase orders, tender documents, invoices, vouchers, receipts, pay bills, TA bills, etc. are maintained and linked to the transactions and are being retained properly.
6. All necessary supporting documents, records and accounts have been kept in respect of all program expenditure including the expenditure covered by the Statements of Expenditure. Clear linkages should exist between the books of accounts and reports submitted to the DoH&FW.
7. Expenditure is incurred with reference to the Annual Work Plan approved by the DoH&FW. In case the budget allocation is exceeded, proper reappropriation, orders from the competent authority, have been obtained.
8. **Reconciliation, with bank statement and SCOVA/DPMU accounts is regularly carried out on monthly basis.**
9. **All books of accounts & prescribed registers are being maintained and kept up to date by making daily entries in such books and registers.**

General points which shall be covered under audit

a. The main purpose of audit of account of a state SCOVA and district RCH society shall be to enforce and ensure that the book of accounts and registers prescribed for various purposes are accurately maintained and kept up to date.

b. Formats prescribed and enclosed with this manual have been adopted in the same way as opened in the manual.

c. Separate savings bank account for RCH Phase II has been opened.

d. Vouchers are prepared on prescribed formats, filled accurately and required documents i.e. original bill/invoice and purchase order etc. have been enclosed with the voucher and necessary entries or certification have been recorded on the bills/cash vouchers etc.

e. Expenditure has been incurred on the same scheme or activity for which it was approved and released by the DoH&FW through state SCOVA.

f. As per the provisions made in the manual for preparation of statements of expenditure (SoE) on monthly, quarterly, six monthly & annual basis are prepared accurately and are based on the figures shown in ledgers & journal.

g. Civil works have been carried out as per the prescribed guidelines and procurement is made in accordance with the procurement guidelines issued by the DOH&FW.

h. Annual physical verification of dead stock non-consumable and consumable articles has been carried out at the end of the financial year.

i. Account records, mainly cash book, petty cash book, ledgers, paid vouchers, bank deposit receipts etc. at district level are kept properly and safely under the custody of the district Chief Medical Officer or by an authorized officer.

j. Paid vouchers and pending liabilities of more than Rs.1,000/- each, may be checked/examined with due care & attention.

k. Proper arrangements for the safety of cash and valuable items have been made.

l. There appears no lapse or weakness or shortcoming in the systems laid down in the manual.

The auditors are expected to comment on the weaknesses/shortcomings observed in the system and make suggestions for its improvement. The audit systems shall assist the implementing agencies to improve the system rather than to criticize them, except in a case where *malafide* intention or criminal conspiracy is established in misuse or embezzlement of funds of the program at any level.

Appendix-14A

Standard Evaluation Sheet for Evaluation of the Technical Bids of the External Auditors (CA Firms)

	Criteria	Remarks	Max. Marks	Marks Obtained
1.	**No. of partners –** FCA/ACA		10	
2.	**Years of experience** Partner A + Partner B + Partner C + Partner D + ...		10	
3.	**Years of Partners association with the firm** Partner A + Partner B + Partner C + Partner D + ...		10	
4.	**No. of Staff** i. Qualified ii. Semi-Qualified iii. Others		 10 5 5	
5.	**Nature of experience** (giving Turnover/Project Cost/ Years of experience of the entities/projects audited) i. RCH audit ii. Govt. Social Sector iii. Other Social sector		 20 5 5	
6.	**No. of Branches**		10	
7.	**Total turnover of the firm in last three years**		10	
		Total	**100**	

Note:
1. In the Invitation Letter, CA Firms will be asked to give details of all these criteria while applying.
2. CA firms will also provide their latest **Certificate of Firm Constitution** as on 1st January of the current year issued by ICAI and their **latest Income Tax Return** duly acknowledge by IT Department. Firms not able to provide these two documents will not be considered.
3. Each member of the evaluation committee will fill up this form separately.
4. Total marks given by all the members will be totalled and the audit work will be awarded to the firm obtaining the maximum marks.

Name of the Member:		Signature with date:	

Appendix-15

Expression of Interest for Short Listing Chartered Accountant Firms for the Audit of the Accounts of State SCOVA and its Dist. PM Units

Status of the Firm: **Partnership** ☐ **Sole Proprietorship** ☐

1. (a) Name of the firm (in capital letters) _____

   (b) Address of the Head Office _____

   (Please also give telephone no. _____

   and e-mail address) _____

   (c) PAN No. of the firm _____

2. ICAI Registration No._____ Region Name _____

   Region Code No. _____

3. (a) Date of constitution of the firm:

   (b) Date since when the firms has a full time FCA

4. Full-time Partners/Sole Proprietor of the firm as on 1st January, ...

S. No.	Years of continuous association with the firm	Number of FCA	Number of ACA
(a)	Less than one year		
(b)	1 year or more but less than 5 years		
(c)	5 year or more but less than 10 years		
(d)	10 year or more but less than 15 years		
(e)	1 5 year or more		

Note: Please attach the copy of Firm's Constitution Certificate issued by ICAI as on 1.1. 200X.

5. Number of Part-time Partners if any, as on 1st January, ...

6. Number of Full-time Chartered Accountants as on 1st January, ...

7. Number of audit staff employed full-time with the firm

   (a) Articles/Audit Clerks _____

(b) Other Audit Staff (with knowledge of book keeping and accountancy) _____

(c) Other Professional Staff (Please specify) _____

8. Number of branches if any _____
(Please mention places & locations)

9. Whether the firm is engaged in any internal or external audit or any other services providing to any Govt. Company/Corporation or co-operative institution etc. Yes/No
If 'yes', details may be given on a separate sheet.

10. Whether the firm is implementing quality control policies and procedures designed to ensure that all audits are conducted in accordance with Statements on **Standard Auditing Practices.** Yes/No
(If yes, a brief note on the procedure adopted is to be enclosed)

11. Whether there are any court/arbitration/any other legal case against the firm Yes/No
(If yes, give a brief note of the case indicating its percent status)

Undertaking

I/We do hereby declare that the above mentioned information are true & correct and I /We also undertake to abide the terms & condition of the contract and would make compliance of terms laid-down in the contract if executed by us with the state SCOVA.

Date:

Place: Signature of Proprietor/Sole Partner

Appendix-16

Terms of Reference (ToR) for Annual Audit (Financial Audit)

1. Introduction

Project background

Reproductive and Child Health program is the flagship program of the Department of Family Welfare combining initiatives in the area of reproductive health, child health and fertility regulations administered in a manner which gives emphasis to quality of services, choice of clients, community participation and gender factors. This program is supported by the World Bank, USAID, European Commission, UNICEF, UNFPA as well as several other bilateral and multilateral donors. World Bank support to the program is routed through two separate projects, one supporting RCH Program activities and other focusing specifically on immunization. Their brief description follows:

Reproductive & Child Health (RCH)

Specific objectives of the program are to:

- Improve the health status of young women and children everywhere in the country.
- Target free approach (T.F.A) for family welfare program. Integrated training under family welfare program and community participation and assessment of quality of care through them.
- Providing increased access for essential and emergency obstetric care and increasing access for safe abortion facilities.
- Facilities for screening and treatment of reproductive and sexual tract infections at the selected health facilities.

Immunization strengthening project

Specific objectives are to strengthen India's Immunization program in order to:

- Eradicate poliomyelitis
- Reduce mortality and morbidity due to six vaccine preventable diseases &
- Strategic medium-term framework development.

The State Committee on Voluntary Agency (SCOVA) is the implementing agency for both Reproductive & Child Health project (RCH) & Immunization Strengthening Project (ISP).

2. Project management

The Directorate of Family Welfare in each State is implementing the Project through State Committee on Voluntary Action (SCOVA). An account opened with a Commercial Bank is used for all transactions of funds received from GoI or any other agency. SCOVA operates the account & is responsible for (a) preparing and submitting SOEs to GoI in the formats of the quarterly / monthly reports are available in the financial management manual. SCOVA is also responsible for ensuring that procurement has been carried out in accordance with the procurement guidelines issued by GoI & agreed with the respective development partners under the respective financing agreement.

3. Objective of audit services

The objective of the audit of the Consolidated Financial Statements (FSs) (Balance Sheet, Income & Expenditure, Receipts & Payments, the Notes and accounting policies) is to enable the auditor to express a professional opinion on the consolidated financial position of the RCH program implemented through the (name of the State) …….. SCOVA at the end of each fiscal year and of the funds received and expenditure incurred for the accounting period ended March 31, 200……., as reported by the financial statements.

The project accounts (books of account as maintained by State and District SCOVAs) provide the basis for preparation of the consolidated financial statements and are established to reflect the financial transactions in respect of the project as maintained by the State/ District SCOVAs as mentioned in para V.

4. Scope of audit services

There shall be a consolidated audit of the accounts of SCOVA and district RCH societies. Audit for the year will include all the components of the RCH, Immunization Strengthening Project (inclusive of Pulse Polio Immunization), and European Commission supported Sector Investment Program (EC-SIP). The concerned auditor will specifically mention in the audit report about the coverage of audit on these components and also will ensure that the releases and expenditures are duly separately reflected in the program financial statements.

The audit will be carried out in accordance with Standards of Auditing issued by the Institute of Chartered Accountants of India in this regard & will include such test & control, as auditors consider necessary under the circumstances. In conducting the audit special attention should be paid to the following:

- An assessment of the adequacy of the project financial management systems, including internal controls. This should include aspects such as adequacy and effectiveness of accounting, financial and operational controls, and any needs for revision; level of compliance with established policies, plans and procedures; reliability of accounting systems, data and financial reports; methods of remedying weak controls or creating them where there are none; verification of assets and liabilities; and integrity, controls, security and effectiveness of the operation of the computerized system. This would be done in every year of project implementation and a specific report on this aspect would be provided by the auditor annually; and
- While conducting audit special attention should be paid to the following :
  - Funds have been spent in accordance with the condition laid down by the Department of Family Welfare, Government of India from time to time with due attention to economy and efficiency, and only for the purpose for which the financing was provided. Audit will be done in accordance with the relevant instructions issued by the GoI.

- Goods and services financed have been procured in accordance with the relevant procurement guidelines issued by the GoI & agreed with development partners.
- Expenditures if any, ineligible for financing by the development partners (as documented in the Development Credit Agreement with the IDA and equivalent agreement with the DFID) are disclosed adequately in the financial statements.
- All necessary supporting documents, records, and accounts have been kept in respect of the Project. clear linkages exist between the books of accounts and reports presented to MOH&FW
- The SoEs submitted during the fiscal year, together with the procedures and internal controls involved in their preparation, can be relied upon to support the related withdrawals.

5. Project financial statement

The project Financial Statement should include:

- Receipt & Payment Account, Income & Expenditure account for the year ending on 31st March, ...
- A summary of funds received showing sources of funds from GoI or any other agency separately identified for both the projects (RCH & ISP).
- A summary of expenditures shown under the main project heading and by main categories of expenditures, both for the current fiscal year and accumulated to date; separately identified for both the projects (RCH & ISP) and
- A balance sheet showing accumulated funds of the project balances, other assets of the project, and liabilities, if any.

As and annex to the Project Financial Statement, the auditor should prepare:

- A reconciliation between the amounts shown as "received by the Project from the GOI" and that shown as being disbursed by the GoI.
- A list of SOEs submitted to GoI under Reproductive & Child Health Program & Immunization Strengthening Project along with their period & amounts.
- The auditor has to ensure that a reconciliation between the expenditure reported as per the SoEs relating to the financial year and the 'expenditure' as per 'Income & Expenditure Statement' is prepared and & a copy of such reconciliation should also be attached.
- Details of assets capitalized as per assets register maintained by the SCOVA.

6. Management letter

In addition to the audit reports, the auditor will prepare a "Management letter", in which the auditor should summarize the observations on internal control issues (other than those which materially affect his opinion on the financial statements)

- Give comments and observation on the accounting records, systems and internal controls that were examined during the course of the audit;
- Identify specific deficiencies and areas of weakness in systems and internal controls and make recommendations for their improvement;
- Report on the level of compliance with the financial/ internal control, procedures as documented in the financial manual of the project;

- Communicate matters that have come to the attention during the audit which might have a significant impact on the implementation of the project; and
- Bring to SCOVA's attention any other matters that the auditor considers pertinent.

The observations in the management letter must be accompanied by the implications, suggested recommendations from the auditors and management comments on the observations/ recommendations from the management.

7. Responsibility of preparing the financial statements

The responsibility of preparing the financial statement shall rest with the project staff under the guidance of auditors. This exercise can be done on half yearly basis however the auditors has to express a professional opinion on the true and fair view of the operations of the Project during the year and the financial position of the project at the close of the fiscal year.

However the responsibility of maintaining accounting records totally rest with the 'Project Staff'

8. Reporting and timing

Apart from the primary opinion on the financial statements, the audit report should include a separate paragraph commenting on the accuracy and propriety of expenditures included in the statements of Expenditure (SOE) Quarterly Financial Reports (QFRs) including whether appropriate procurement procedures have been followed, and the extent to which the GoI can rely on SOE/QFRs.

The auditor's report should cover the following other statutory certifications as applicable to societies registered under 'Societies Registration Act 1860) or relevant State Societies Registration Acts as appropriate.

The audit should be carried out each year and the final audit report should be submitted by 31st July, (i.e. within four months after the end of the financial year), to the SCOVA & SCOVA should then promptly forward copies of the audited financial statement and audit reports to GoI together with their comments, if any.

9. Key personnel

The key personnel in the audit team, their minimum qualifications, and their anticipated inputs are indicated below:

- The Audit team should be led by a chartered accountant with a minimum 10 year experience in audit. The anticipated input of the CA is about 15 working days each year.
- The audit team should include sufficient number of appropriate staff (audit seniors, junior staff, etc.), commensurate with the size and scope of the assignment.

10. General

The auditor would be given access to all documents, correspondence, and any other information, which is deemed necessary by the auditor, relating to the project. The auditor should obtain confirmation of amounts disbursed and outstanding from GoI. The auditor would be provided copies of the legal agreements, MoU between the GoI and the States, finance and accounts manual, procurement guidelines, policies and procedures issued by project management. The auditor will maintain working papers in a systematic manner and make them available to GoI for review if required.

Appendix-17

Name of the State/UT SCOVA or District RCH Society _____

Receipt & Payment Account for the year ended March 31, ...

Receipts	Sch. Ref.	Amount	Payments	Sch.Ref.	Amount
Opening Cash & Bank Balances as on 1st April, ...			**1. Disbursements to the Districts:**		
■ Cash in hand			i) Out of Grants-in-aid		
■ Bank Balances			received from GoI		
■ Cheques/drafts in hand			for activities as per		
			District Action Plans		
Grants received from:			(Activities to be		
i) Government of India			listed if mentioned		
■ Towards flexi-pool			while releasing grants)		
■ Pulse Polio					
■ EC SIP					
■ Area Projects					
■ Civil Works, etc.					
■ Others *(to be specified)*			ii) Out of Grants received		
			from WHO		
ii) WHO on account of IPPI:			■ Training		
■ Training			■ IEC		
■ IEC			■ Booth Management		
■ Booth Management					
			iii) Out of NIHFW grants:		
			■ Awareness generation training		

Contd....

Receipts	Sch.Ref.	Amount	Payments	Sch.Ref.	Amount
iii) NIHFW on account of:			■ Skill based training		
■ Awareness generation training					
■ Skill based training			**2. Payments at State:**		
			Out of Grants-in-aid		
			received from GOI		
Bank Interest			■ Contractual Staff		
			■ Audit Fees		
Refunds from districts, etc.			■ Bank Charges		
			■ Any other (specify)		
Any other receipt *(Pl. specify)*					
			Out of Grants received		
			from WHO		
			■ IEC		
			Closing Cash & Bank Balances as on 31st March, ...		
			■ Cash in hand		
			■ Bank Balances		
			■ Cheques/drafts in hand		
Total (Rs.)			**Total (Rs.)**		

Appendix-18

Name of the State/UT SCOVA or District RCH Society _____

Income and Expenditure Account for the year ended March 31, ...

Expenditure	Sch.Ref.	Amount	Income	Sch.Ref.	Amount
1. At Districts:			Grants transferred from Balance Sheet to the extent of expenditure		
i) Out of Grants-in-aid received from GoI					
■ Towards flexi-pool(break-up of the activities to be provided in line with **Appendix-5**)			i) Out of Grants-in-aid received from GOI		
■ Pulse Polio			for activities as per		
■ EC SIP			District Action Plans		
■ Area Projects			(Activities to be		
■ Civil Works, etc.			listed if mentioned		
			while releasing grants)		
■ Others *(to be specified)*					
■ Bank Charges			ii) Out of Grants received		
			from WHO for IPPI		
			■ Training		
ii) Out of Grants received from WHO			■ IEC		
			■ Booth Management		
■ Training					
■ IEC			iii) Out of NIHFW grants:		
■ Booth Management			■ Awareness generation training		
			■ Skill based training		
iii) Out of NIHFW Grants					
■ Awareness generation training			Bank Interest		
■ Skill based training			■ At State		
			■ At Districts		

Contd....

Expenditure	Sch.Ref.	Amount	Income	Sch.Ref.	Amount
2. At State					
Out of Grants-in-aid from GOI					
■ Contractual Staff			**Any other income** *(Pl. specify)*		
■ State level consultants					
■ Audit Fees					
■ Bank Charges					
■ Any other (specify)					
Out of Grants from WHO					
■ IEC					
Any other expenditure *(specify)*					
Excess of Income over Expenditure carried to the Balance Sheet					
Total (Rs.)			**Total (Rs.)**		

Appendix-19

Name of the State/UT SCOVA or District RCH Society _____

Balance Sheet as at March 31, ...

Liabilities	Sch. Ref.	Amount	Assets	Sch. Ref.	Amount
Grant/Fund Account			**Fixed Assets**		
(balance in grant/fund account after expenditure)			(attach schedule showing head-wise Assets)		
i) From Government of India on account of:					
■ Towards flexi-pool			**Current Assets, Loans & Advances**		
■ Pulse Polio					
■ EC SIP			i) Out of Grants received		
■ Area Projects			from GoI:		
■ Civil Works, etc.			■ Towards flexi-pool		
			■ Pulse Polio		
■ Others *(to be specified)*			■ EC SIP		
			■ Area Projects		
			■ Civil Works, etc.		
ii) From WHO on account of IPPI:					
■ Training			ii) Out of Grants received		
■ IEC			from WHO for IPPI		
■ Booth Management			■ Training		
			■ IEC		
			■ Booth Management		
			iii) Out of NIHFW grants:		
iii) From NIHFW on account of:			■ Awareness generation training		
■ Awareness generation training			■ Skill based training		
■ Skill based training					

Contd....

Liabilities	Sch. Ref.	Amount	Assets	Sch. Ref.	Amount
Surplus being excess of Income over Expenditure as on April 1, ...			**Interest Income at district - net of bank charges (receivable from districts)**		
Add: Surplus for the year					
			Cash & Bank Balances:		
Capital Fund Account			Bank Balance		
(created to the extent of assets			Cash in hand		
capitalised)			Cheques/drafts in hand		
Total (Rs.)			**Total (Rs.)**		

Appendix-20

Reproductive and Child Health Program Phase II

Schedule of Fixed Assets as on 31st March _____

Name of the State SCOVA _____ Name of the DPM Unit _____

S. No.	Item with description	Source of Purchase / Procurement	Invoice / Bill Number and Date	Exp. incurred	Value of the assets without any depreciation
1	2	3	4	5	6
	Total				

Place : _____

Date : _____

State RCHP Officer
or
District RCHP Officer

Appendix-21

Format of Audit Report

Introduction

We have audited the accompanying expenditure statements/financial statements of the RCH Program implemented through the District/ State _____ SCOVA as of March 31, 20XX. Our responsibility is to express an opinion on these financial statements based on our audit.

Scope

We conducted our audit in accordance with established standards of auditing of the Institute of Chartered Accountants of India. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles use and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audit provides a reasonable basis for our opinion.

Opinion

a. The statements of account dealing with this report includes funds received from **World Bank under Reproductive and Child Health Program (Cr. No. No. .....), Immunization Strengthening Project (Cr. No. ……) and EC supported Sector Investment Program (EC-SIP).**

b. We have obtained all the information and explanation, which to the best of our knowledge and belief were necessary for the purpose of our examination.

c. In our opinion, proper books of account have been kept by the SCOVA society, so far as appears from our examination of the books.

d. The statements of account dealt with this report are in agreement with the books of account.

e. In our opinion and to the best of our information and according to the explanation given to us the said accounts, subject to (state qualifications if any) gives the information in the manner so required and give a true and fair view:-

   1. In the case of the balance sheet, of the State of affairs of the Society as at 31st March, ...
   2. In the case of the Income and Expenditure Account of the excess of income over expenditure/ deficit of income over expenditure for the year ended on that date.
   3. In case of Receipts & Payments Account of the receipts and payments during the year ended on that date.

f. In addition with respect to SoEs/QFR, adequate supporting documentation has been maintained to support claims to the World Bank for reimbursements of expenditures incurred; and

g. The expenditures so claimed are eligible for financing under the Loan/Credit Agreement of Reproductive and Child Health Program (Cr. No. .....) and Immunization Strengthening Project (Cr. No.).

Place:

Date: Signature of Auditor(s)

Note:

In case a qualified opinion or disclaimer is given by the auditor, the audit report should state in a clear and informative manner all the reasons for such an opinion.

Audit report to be accompanied by:

a. Management Letter

b. Listing of SoE withdrawal applications sent by the State Society to GoI

c. Listing on ineligible expenditures if any

d. Reconciliation of SoE claims sent to GoI with the actual expenditure as reported in the audited financial statements

Appendix-22

Management Letter

(Specimen Format)

Part 'A'

Observation by Auditor in Current Year (Year.....)	Compliance

Part 'B'

Observation by Auditor in Previous Years (Year 200..-200.., 200..-200.., 200..-199.., 199..-199... .....)	Compliance

Letter of Undertaking

Dated : .....

The Secretary

Government of India

Ministry of Health and Family Welfare

Department of Health

New Delhi

Ref. : Reproductive & Child Health II Project - Letter of Undertaking [LOU]

Sir,

We refer to the Development Credit Agreement (the DCA) between India (hereinafter referred to as "Government of India") and International Development Association (hereinafter referred to as the "Association") for the Reproductive & Child Health II Project (the "Project") dated _____ under which the Association agreed to make available to the Government of India an amount in various currencies equivalent to _____ the credit on the terms and conditions set forth in DCA.

In consideration of the Association's entering into the Development Credit Agreement with the Government of India, we have agreed to undertake the obligation set forth in this Letter of Undertaking.

We hereby declare our commitment to the objectives of the Project as set forth in Schedule 2 to the DCA and agree to undertake its portions of the Project with due diligence and efficiency and in conformity with appropriate health practices and to provide funds, facilities, services and other resources required therefore.

Without limitation upon the foregoing provisions and as Government of India and the Association may otherwise agree, we shall carry out our portion of the Project as follows:

(a) We declare our commitment to the objectives of the Project as set forth in Schedule 2 to this Agreement, and to that end, it shall agree to undertake its portion of the Project with due diligence and efficiency and in conformity with appropriate health and family welfare practices, and to provide, promptly as needed, the funds, facilities, services and other resources required there for.

(b) In consideration of the Government of India providing the budgetary allocations to us, we agree to assume all the obligations applicable or relevant to the Project States and/or SIA under this Agreement and to take all actions necessary to undertake its portion of the Project. We further agree to carry out our portion of the Project as follows:

- We shall (i) carry out activities under the Project in accordance with our SPIP agreed with the Borrower and forming part of the NPIP, and shall (ii) carry out civil works under the Project in accordance with the technical manual (as applicable) developed by the Borrower, as such manual may be revised from time to time in agreement with the Association; and
- we shall appoint key additional staff according to our approved AWP and SPIP.

(c) We shall undertake to procure the goods, works and consultants' services required for the Project and to be financed out of the proceeds of the Credit under this Agreement in accordance with the provisions of Schedule 3 to the DCA.

(d) We agree that the Borrower or the Association may from time to time inspect the goods, works and services under the Project including all records and documents relating thereto.

(e) We agree to assume and undertake the obligations set forth in Sections 9.03, 9.04, 9.05, 9.06, 9.07 and 9.08 (relating to insurance, use of goods and services, plans and schedules, records and reports, maintenance and land acquisition, respectively) of the General Conditions applicable to the DCA in respect of this Letter of Undertaking [LOU] and our portion of the project.

(f) We assume and undertake to comply or assist the Borrower in complying with the financial covenants prescribed by Article IV of the DCA. We also agree that the Borrower may suspend or terminate our right to use the proceeds of the Credit made available under this LOU upon our failure to perform any obligations under our LOU or upon notice by the Association that it intends to exercise its remedies under Article V of the DCA.

(g) We agree to inform the Borrower and the Association promptly of any condition which interferes or threatens to interfere with the progress of our portion of the Project, the accomplishment of the purposes of the Credit under the DCA, or the performance of our obligations under this LOU.

(h) We agree that we shall, from time to time, at the request of either the Borrower or the Association, (i) exchange views with the Borrower and/or the Association (through the Borrower) with regard to the progress of carrying out activities under our portion of the Project, our performance under our Letter of Undertaking and other matters relating to the purposes of the Credit under the DCA, and (ii) furnish all such information related thereto as may reasonably be required by the Borrower to fulfill its supervision, monitoring and reporting obligations to the Association. We also agree to afford all reasonable opportunity for representatives of the Association to visit any part of its territory for purposes related to the Project.

(i) We agree to maintain our Project Executing Agencies to oversee Project activities within such Project State and to coordinate Project activities with the Borrower's National Program Coordination Committee.

(j) Except as the Borrower and the Association shall otherwise agree, we agree either to (i) utilize the services of MOFW's national-level procurement support; (ii) to establish or engage a State-level Procurement Support Agency with terms of reference, resources and staff satisfactory to the Borrower and the Association, for procuring goods, works and services; (iii) [in the case of those Project States with existing procurement units acceptable to the Borrower and Association,] utilize such existing procurement units, for procuring goods, works and consultants' services required for the Project; or (iv) improve the logistics and storage facilities in time-bound manner to the satisfaction of the Borrower and the Association.

(k) We agree to establish a mechanism acceptable to the Borrower and the Association for the transfer of funds from the State level to the Project Executing Agencies at District or institutional levels. Without limitation upon the provisions of Section 4.01 of the DCA, we agree to open, establish and maintain a separate Project account in each District or institution receiving Credit proceeds, and we agree to prepare monthly consolidated state expenditure reports in respect of all such Project accounts.

This Letter of Undertaking shall be complemented within one year's time of the RCH II Project's effectiveness by a Memoranda of Understanding between the MOHFW and us, and acceptable to the Borrower and the Association.

We realize that non-compliance with any of our obligations under this Letter of Undertaking will be tantamount to an event of default which will enable the Association to suspend in whole or in part the right of Government of India to make withdrawals from Credit under the DCA.

This Letter of Undertaking shall be effective from the date of its signature by the authorized representative below.

Yours faithfully,

National Rural Health Mission

Draft Memorandum of Understanding (MoU) Between Ministry of Health & Family Welfare, Government of India And The Government of the State of .....

1. Preamble

1.1 *WHEREAS* the Union Cabinet has approved the National Rural Health Mission, hereinafter referred to as NRHM, for nation-wide implementation with effect from April, 2005;

1.2 *WHEREAS* the NRHM aims at providing accessible, affordable, effective, accountable and reliable health care to all citizens and in particular to the poorer and vulnerable sections of the population; consistent with the outcomes envisioned in the Millennium Development Goals and general principles laid down in the National and State policies, including the National Health Policy, 2002 and National Population Policy, 2000.

1.3 *AND WHEREAS* an 'architectural correction' of the health sector is a key objective for the NRHM, to be carried out through integration of vertical programs and structures; delegation and decentralization of authority; involvement of Panchayati Raj Institutions and other supportive policy reform measures in the areas of medical education, public health management, incorporation of Indian Systems of Medicine, regulation of health care providers and new health financing mechanisms;

1.4 *NOW THEREFORE* the signatories to this Memorandum of Understanding (hereinafter referred to as MoU) have agreed as set out herein below.

2. Duration of the MoU

2.1 This MoU will be operative with effect from April, 2005 or the date of its signing by the parties concerned whichever is later and will remain in force till March, 2012 or till its renewal through mutual agreement whichever is earlier.

3. Financial Assistance

3.1 The Ministry of Health & Family Welfare will provide a resource envelope for supporting the policies and programs proposed to be undertaken by the State under the National Rural Health Mission. Although different (existing) vertical budget lines under the MoH&FW are expected to collapse into a common NRHM pool, for the present the State Governments may retain sub budget lines, in accordance with the existing bilateral agreements between the GoI/State Governments and the Development Partners.

3.2 Although the AIDS control program and the National Cancer Control Program shall not be merged into the NRHM, the planning and monitoring functions for these shall remain a specific task for the institutional arrangements agreed through this MoU.

4. Program Implementation Plan

4.1. Each State will prepare a Sector Program Implementation Plan (PIP) and a Log Frame which will reflect activities proposed to be undertaken both through GoI funding as well as through the States own resources including activities falling under State Partnership Program directly funded

by the Development Partners. The Sector PIP will also reflect efforts at convergence with related sectors including AYUSH, Rural Development, Sanitation, Drinking Water, Nutrition, Women and Child Development, etc.

4.2. The PIP will be consistent with the general principles laid down in the National and State policies relevant to the Sector and other agreed action plans including that of JSY and the UIP Multi Year strategic plan. The Log Frame will in particular reflect the core indicators agreed to be adopted by the program.

4.3 Based upon its PIP and Log Frame, each State will set its own annual level of achievement for the program core indicators and subsequently, States will have similar arrangements with the Districts.

4.4. The Government of India will issue mandatory core financial and program indicators as well as institutional process as well as output indicators which would need to be adhered to by the States.

4.5. At the level of each State / UT the implementation of the action plan as set out in the PIP shall be reviewed once every month.

4.6. A review would be held every (quarter/six months) by the MoH&FW (for the EAG States, NE States, the State of Jammu and Kashmir and Himachal Pradesh) every six months/annually (for other States/UTs). Corresponding State level reviews of Districts would need to be carried out by the States/UTs.

5. Institutional arrangements : National Level

5.1. The NRHM shall have a Mission Steering Group (MSG) Chaired by the Union Minister of Health and Family Welfare which shall lay down policies and programs for the Health Sector and an Empowered Program Committee (EPC) Chaired by the Secretary, Health & Family Welfare. The MSG shall meet at least twice a year and it will have the powers of the Union Cabinet for approving financial proposals recommended by the Empowered Program Committee (EPC). Four Secretaries (Health & Family Welfare) of high focus States shall be nominated as members of the MSG for a period of one year each by rotation, by the Government of India. The EPC will operate the overall budget of the Ministry of Health & Family Welfare and it will function as the Expenditure Finance Committee for the Mission.

5.2. The State Plans shall be appraised by a National Program coordination committee (hereinafter called the NPCC) of the MoH&FW headed by Additional Secretary (NRHM) and will consist of the officers of the MoH&FW.

5.3. The representatives of the concerned State Government(s) may also be invited to the NPCC whenever their proposal are listed for consideration / approval.

5.4. The NPCC may also seek written feedback on the State Plan(s) from the representatives of the Development Partners providing financial and technical assistance to the Mission in the concerned State(s).

6. Institutional arrangements : State, District and Hospital Levels

6.1. The State Government has set up the State Mission Steering Group (hereinafter referred to as SMSG) headed by the Chief Minister.

6.2. The State has also designated a full time Mission Director.

6.3. The State has merged existing State level vertical societies in the health sector and has created an integrated Society called …… The said society shall receive the funds from the MoH&FW and other sources. The Society shall also perform the functions of a flexible mechanism for sourcing program management support for the State Directorate and district health administration.

6.4. The State has ordered merger of all District level vertical societies into an integrated district health and family welfare society called……. The district level society shall perform functions similar to that of the State level society, namely to receive funds and to provide program management support to district administration.

6.5. The State has also decided to set up a Patient Welfare Society at the hospital level called ……

6.6. The agreed State and district level organograms, scope of functions for the secretariat of the State and district societies and other relevant details including delegation of financial powers to the authorities of the State and District level societies are given at **Appendix-I (State PIP and Log Frame** *to be prepared and sent by the State Government along with the signed copy of this MoU***)** hereto.

7. Core Indicators

7.1. The State has agreed to a set of *Core Indicators* with specific reference to service delivery levels especially for SC/ST/ vulnerable beneficiaries to reflect the progress of implementation, including the institutional reforms.

7.2. The agreed Core Indicators, the agreed time frame for *milestones* to be achieved and the *evidence* to be made available in support of the achievement are given at **Appendix-II** and **III** hereto.

8. Funds Flow Arrangements

8.1. The MoH&FW shall adopt a six-monthly funds release system to support the agreed State Plan.

8.2. The first installment of agreed grants-in-aid shall be released upon the execution of this MoU or till such time by a letter of Undertaking by the state.

8.3. Subsequent releases shall be regulated on the basis of submission of a report by the State indicating the progress of the agreed State Plan including the following:

- Documentary evidence indicating achievement of milestones for the agreed core indicators,
- Statement of Expenditure confirming utilization of at least 50% of the previous release(s),
- Utilization Certificate(s) and Audit reports wherever they have become due as per agreed procedures under General Financial Rules (GFR), 1963 and / or relevant instructions on the subject.

9. Performance Awards

9.1. The State shall be eligible to receive an Annual 'performance award' to the tune of 10% of its *actual utilization* of cash assistance in the previous financial year provided that the State has successfully achieved the criteria set out in para 7.2 above.

9.2. The releases under the performance award mechanism will be over and above the agreed allocations as set out in para 3.1 above and will become an untied pool which may be used for such purposes as may be agreed by the State Mission Steering Group referred to in para 5.1 hereinabove.

10. Annual Review

10.1. The agreed State Plan and the progress and achievements thereof will be subject to joint annual review.

10.2. The agreements to add to or modify this MoU will always be in writing and will form part of the minutes of National Program coordination committee referred to in para 5.4 hereinabove.

11. Government of India Commitments

11.1 The funds committed through this MoU may be enhanced or reduced, depending on the pace of implementation of the agreed State Plan, achievement of the milestones relating to the agreed *Core Indicators* agreed reform program and achievement of the agreed levels of the process indicators drawn from the agreed State Plan.

11.2 The MoH&FW also commits itself to:

(a) Ensuring that the resources available under the State Partnership Programs outside the MoH&FW budgets are directed towards complementing and supplementing the resources made available through the MoH&FW budget and are not used to replace the recurring expenses hitherto provided for under the Centrally Sponsored Schemes under the health and family welfare sector.

(b) Ensuring that multilateral and bilateral development partners co-ordinate their assistance, monitoring and evaluation arrangements, data requirements and procurement rules etc. within the framework of an integrated State Health Plan.

(c) Assisting the States in mobilizing technical assistance inputs to the State Government including in the matter of recruitment of staff for the State and district societies.

(d) Facilitating establishment of District Health Missions and development of District Action Plans through such means as may be mutually agreed.

(e) Developing social / equity audit capacity of the States through joint development of protocols for assessing access levels for the most disadvantaged groups.

(f) Developing and disseminating protocols, standards including the Indian Public Health Standards (IPHS), training modules and other such materials for improving implementation of the program.

(g) Consultation with States, at least once a year, on the reform agenda and review of progress.

(h) Prompt consideration and response to requests from states for policy, procedural and programmatic changes wherever considered necessary.

(i) Release of funds on attainment of agreed milestones and process indicators, within an agreed time.

(j) Holding joint annual reviews as well as a mid term review with the State, other interested Central Departments and participating Development Partners; and prompt corrective action consequent on such reviews.

(k) Dissemination of and discussion on any evaluations, reports etc., that have a bearing on policy and/or have the potential to cause a change of policy.

12. State Government Commitments:

12.1 The State Government commits to ensure that the funds made available to the State level Societies to support the agreed State Plan under this MoU are:

(a) used for financing the agreed State Plan in accordance with agreed financing schedule and not used to substitute routine expenditures which is the responsibility of the State Government.

(b) kept intact and not diverted for meeting ways and means crises.

12.2 The State Government also commits to ensure that:

(a) The share of public spending on health from state's own budgetary sources will be enhanced at least at the rate of 10% every year.

(b) Its own resources and the resources provided through this MoU to the State level Societies flow to the districts on an even basis so as to ensure regular availability of budget at the district and lower levels.

(c) District health funds and District Health Missions will be established within an agreed time frame under the effective supervision of the Panchayati Raj Institutions for supporting and implementing the policies and programs of the NRHM.

(d) Structures for the program management are fully staffed and the key staff related to the design and implementation of the agreed State Plan, agreed reform program and other related activities at the State (including Directorate) and district level are retained in their present positions at least for three years.

(e) Representative of the MoH&FW and/or development partners providing financial assistance under the MoU mechanism as may be duly authorized by the MoH&FW from time to time, are allowed to undertake field visits in any part of the State and have access to such information as may be necessary to make an assessment of the progress of the health sector in general and the activities related to the activities included under this MoU, subject to such arrangements as may be mutually agreed.

(f) The utilization certificates (duly audited) are sent to the Ministry of Health & after close of the financial year, within the period stipulated in the General Financial Rules, 1963 and / or relevant instructions on the subject.

(g) State and district society funds will be kept in interest bearing accounts for each program in a designated bank and such interest is used to meet the day-to-day office expenses of the said societies.

12.3 The State Govt. agrees to abide by all the existing manuals, guidelines, instructions and circulars issued in connection with implementation of the NRHM, which are not contrary to the provisions of this MOU.

12.4 The State Government also commits to take prompt corrective action in the event of any discrepancies or deficiencies being pointed out in the audit. Every audit report and the report of action taken thereon shall be tabled in the next ensuing meeting of the Governing Body of the State Society.

13. Bank accounts of the societies and their audit:

13.1 The State will ensure that the State and district societies organize the audit of their accounts within six-months of the close of every financial year. The State Government will prepare and provide to the MoH&FW, a consolidated statement of expenditure, including the interest that may have accrued.

13.2 The funds routed through the MoU mechanism will also subject to statutory audit by the Comptroller and Auditor General of India. In addition they shall also subject to audit in accordance with the Financial Rules of the Society holding the funds released by MoH&FW under this MoU and any GoI obligations under the bilateral agreements with Development Partners. The Internal Audit Wing of the Ministry of Health and Family Welfare shall also be doing "Special Audit" on requirement basis.

13.3 The State Government shall take prompt corrective action in the event of any discrepancies or deficiencies being pointed out in the audit. Every audit report and the report of action taken thereon shall be tabled in the ensuing meeting of the Governing Body of the concerned Society.

14. Suspension

14.1 Non compliance of the commitments and obligations set hereunder and/or upon failure to make satisfactory progress may require Ministry of Health & Family Welfare to review the assistance committed through this MoU leading to suspension, reduction or cancellation thereof. The MoH&FW commits to issue sufficient alert to the State Government before contemplating any such action.

Signed this day, the ..... of ..... 200 .

For and on behalf of the
Government of .....
Department of Health & Family Welfare,

Chief Secretary, Government of
Date:_____

For and on behalf of the
Government of India, Ministry of Health & Family Welfare,

Secretary, Ministry of Health & Family Welfare,
Government of India
Date:_____

Appendix-II

Financial Management Indicators

A. Finance and HRD related indicators

1. Qualified and skilled finance manpower in place & trained:
   - At State level
   - At District level
2. Vacancy Position of the Finance and Accounts Staff:

	No. of Sanctioned Posts	No. of Staff in position	No. of Vacancy	Since when Vacant (Give date)	Reason for Vacancy	Action Plan & time frame for filling up the vacancy
State level						
District level						

3. Integration and empowerment of finance personnel into the system:
   - Organograms of State and District level finance staff submitted to GoI
   - GO issued specifying duties and channel of reporting.
4. Training of Finance personnel completed:
   - State level finance and accounts staff trained by GoI
   - District level finance and accounts staff trained by State Government.
5. Dotted line relationship with the Central FMG:
   - Performance of contractual Finance and Accounts staff evaluated on yearly basis and evaluation sheet forwarded to FMG, MoH&FW, GoI.
   - Concurrence of central FMG taken for yearly extension of tenure of finance and accounts staff.

B. Financial empowerment related indicators

1. Delegation of adequate Financial and Administrative Powers:
   - Govt. Order (GO) or resolution of SCOVA delegating the financial and administrative powers submitted to GoI:
     - At State level adequate powers delegated to the ED/Project Director

- At District level adequate powers delegated to the CMO
- At PHC/CHC levels, retention and full powers for use of User charges collected there.

2. Adequate infrastructure facilities, e.g. computers, printers, telephone, fax, internet connection, etc. provided to Finance and Accounts staff:
   - at State level
   - at District level

C. Financial performance related indicators

1. Financial report (Quarterly, in the format prescribed)

Quarterly							
State	Timely (within a month after the end of quarter)	Delay of 1 Month	Delay of 2 Months	Delay over 2 Months	No. of Districts omitted	Quality of Financial Reports	Action taken to overcome delays in future

2. Audited statement of accounts & audit reports

Annual								
State	Timely by 31st July	Delay of 1 Month	Delay of 2 Months	Delay over 2 Months	No. of Districts omitted	Quality of audit Reports	No. of Audit observations	Action taken to overcome delays in future

3. Utilization certificates

Annual						
State	Timely, along with Audited Statements of Accounts by 31st July	Delay of 1 Month	Delay of 2 Months	Delay over 2 Months	Quality of UCs submitted	Action taken to overcome delays in future

4. Expenditure report

Previous year's available funds	Funds received		Funds utilized		Unspent balance carried forward to next financial year
	1st Installment	2nd Installment	1st half of the year i.e. up to 30th September	2nd half of the i.e. up to 31st March	

Appendix-IIIa

Performance Indicators

Institutional process performance targets whereby release of (2006/7) flexible pool resources will be decided

S. No.	Indicator	Source	Target level of achievement set by the state*	Date on which the indicator is to be measured
1.	% of ANM positions filled	State reports and quarterly management reviews		
2.	% of states and districts having full time program manager for RCH with financial and administrative powers delegated	Same as above		
3.	% of sampled state and district program managers aware of their responsibilities	Management review		
4.	% of sampled state and district program managers whose performance was reviewed during the past six months	Management review		
5.	% of districts not having at least one month stocks of (a) Measles vaccine, (b) Oral Contraceptive Pills and (c) Gloves	MIS		
6.	% of districts reporting quarterly financial performance in time	FMR		
7.	% of district plans with specific activities to reach vulnerable communities	Management reviews		
8.	% of sampled districts that were able to implement M&E triangulation involving communities	Management reviews		
9.	% of sampled outreach sessions where guidelines for AD syringe use and safe disposal are followed	Quality reviews		
10.	% of sampled FRUs following agreed infection control and healthcare waste disposal procedures	Quality reviews		
11.	% of 24 hrs PHCs conducting minimum of 10 deliveries/month	MIS and quality reviews		
12.	% of upgraded FRUs offering 24 hr. emergency obstetric care services	MIS and quality reviews		

Appendix-IIIb

Output indicators from Mid Term and End Line Surveys, to be used to determine releases from 2008/9 onwards.

The states are to set target levels of achievement for these indicators based on their own assessments.

1. Contraceptive prevalence rate
2. % eligible couples using any spacing method for more than 6 months
3. % of women delivered during past one year who received 100 IFA tablets
4. % deliveries conducted by skilled providers (doctors, nurses or ANMs)
5. % of 24 hrs PHCs conducting minimum of 10 deliveries/month
6. % of upgraded FRUs offering 24 hr. emergency obstetric care services
7. % of 12-23 months children fully immunized
8. % of mothers and newborn children visited within 2 weeks of delivery by a trained community level health provider/AWW or health staff (ANM/Nurse/Doctor)
9. % of children suffering from diarrhea during past 2 weeks received Oral Rehydration Solution
10. Polio free status achieved since

Details of numerator and denominator and sources of information given in Appendix IV.

Indicators suggested for performance bonus

% of allocated funds for the year disbursed	<10%	10-20%	20-30%	30-40%	40-50%	50-60%	60-70%	70-80%	80-90%	>90%
Score	1	2	3	4	5	6	7	8	9	10
% contributed by SC/ST populations among deliveries reported by public facilities compared to population in state *	%age in State +/- 5%			5-15% above %age SC/ST population in State			over 15% above %age SC/ST population in State			
Score	3			6			10			
% achievement of planned measles coverage among SC/ST population *	<10%	10-20%	20-30%	30-40%	40-50%	50-60%	60-70%	70-80%	80-90%	>90%
Score	1	2	3	4	5	6	7	8	9	10

* These indicators are to be validated every year by an independent agency

It is proposed to give equal weight for disbursements and each of the indicators for improved program performance. For both program performance indicators, the attention would be on improving coverage for SC/ST populations which has to be validated by independent agencies. These indicators would be appropriately modified to suit the needs of the states. For example, in case of NE states, monitoring changes would be correlated with BPL populations, not ST.

Performance based disbursements

From fiscal year 2006/7 onwards the MoH&FW would decide whether to release an amount of flexible pool resources in addition to that specified above for encouraging good performance. The release to [state or UT] would be set by the following formula:

Release = Rs [ ] crore x

{(50 x % of funds allocated by the state and central government for the previous year disbursed)

+ (25 x % of SC/ST deliveries attended by ANM/nurse/doctor)

+ (25 x % achieved of planned measles coverage among [SC/ST/Below Poverty-Line] population)}

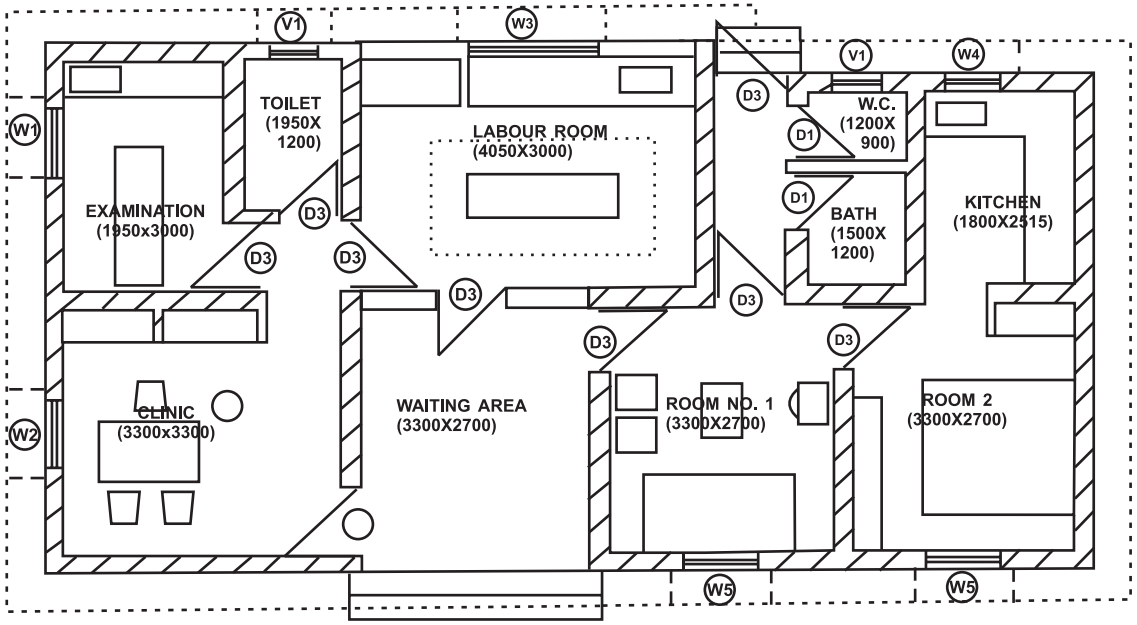
Appendix-IV

Details of Calculation of Key Indicators

Indicator	Numerator	Denominator	Source of Information	Expected Frequency
1. Contraceptive Prevalence Rate	Number of sampled/ listed eligible couples using one or other modern method of contraception	Total number of eligible couples sampled/listed	■ Household surveys/ NFHS 3 ■ MIS	■ Twice /once during project period ■ Annual
2. Eligible couples using any spacing method for more than 6 months	Number of sampled/ listed eligible couples using one or other spacing methods for more than 6 months	Total number of eligible couples sampled/listed <30 years	■ Household surveys/ NFHS 3 ■ MIS	■ Twice /once during project period ■ Annual
3. Pregnant women receiving 100 or more IFA tablets	Number of women who delivered during past one year receiving 100 or more IFA tablets	Number of women who delivered during past one year	■ Household surveys/ NFHS 3	■ Twice/once during project period
4. Deliveries conducted by skilled providers	Number of women delivered during past one year by skilled providers	Number of women delivered during past one year	■ Household surveys/ NFHS 3 ■ MIS	■ Twice /once during project period ■ Annual
5. Twenty-four hour PHCs conducting at least 10 deliveries in a month	Number of 24 hr. PHCs conducting 10 or more deliveries in a month	Number of 24 hr. PHCs surveyed/ reporting	■ Facility Surveys ■ MIS	■ Twice during project period ■ Quarterly
6. Upgraded FRUs offering 24 hr. emergency obstetric care	Number of upgraded FRUs offering 24 hr. emergency obstetric care	Number of FRUs surveyed/reporting	■ Facility Surveys ■ MIS	■ Twice during project period ■ Quarterly
7. 12-23 months children fully immunized	Number of sampled/ listed 12-23 months children fully immunized	Number of 12-23 months children sampled/listed	■ Household surveys/ NFHS 3 ■ MIS	■ Twice/once during project period ■ Annual

Contd....

Indicator	Numerator	Denominator	Source of Information	Expected Frequency
8. Mothers and newborn visited as per schedule within 2 weeks of delivery by a trained community level health provider/ AWW or health staff (ANM/Nurse/Doctor)	Number of Mothers and newborn visited as per schedule within 2 weeks of delivery by a trained community level health provider/ AWW or health staff (ANM/Nurse/Doctor)	Number of mothers delivered during past one year	■ Household surveys/ NFHS 3 ■ MIS	■ Twice/once during project period ■ Annual
9. Children suffering from diarrhea given ORT	Number of children who suffered from diarrhea during past two weeks and received ORS	Number of children who suffered from diarrhea during past two weeks	■ Household surveys/ NFHS 3	■ Twice/once during project period
10. Zero free polio status achieved since	No of districts reporting no polio cases	Number of districts with non polio AFP rate more than one	■ National Polio Surveillance Program	■ Continuous



SUBCENTER

COVERED AREA - 73.50 SQ. MTS.

NOTE :

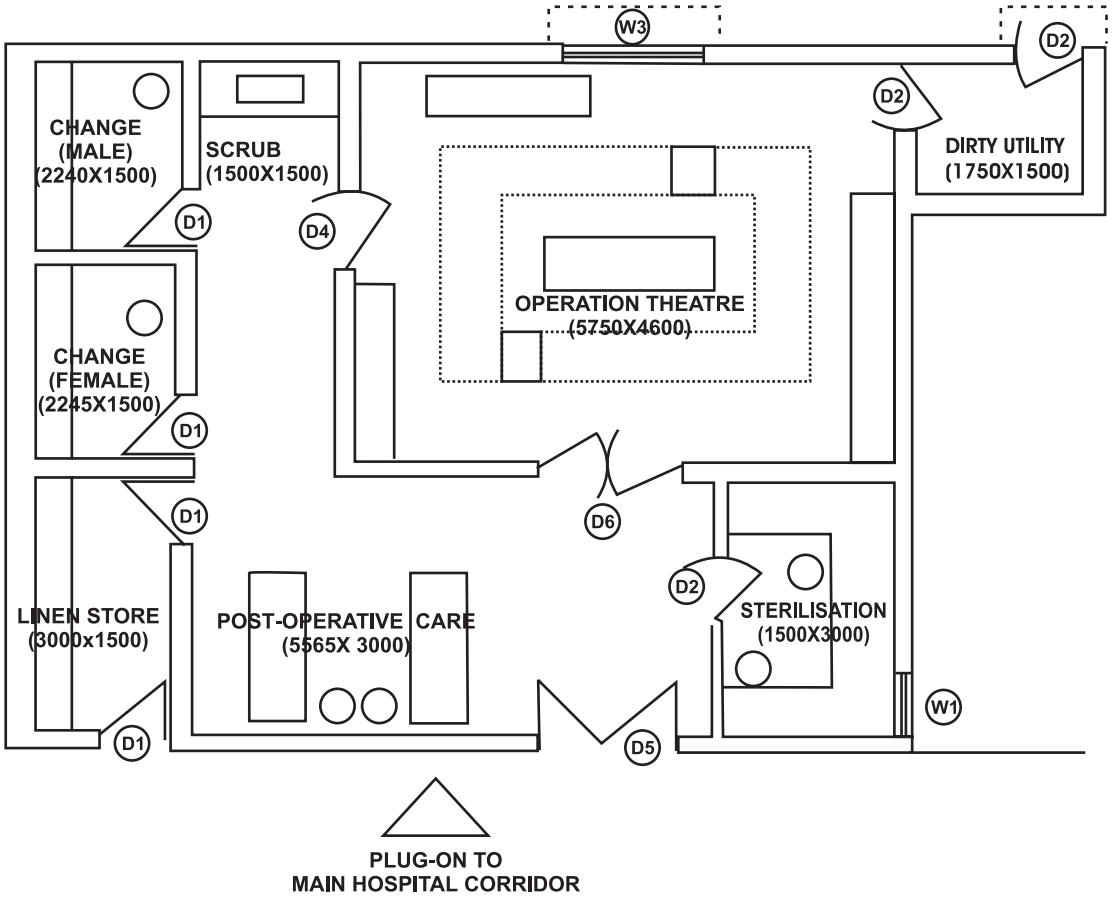
The layout shown ensures proper linkages amongst various activity areas while also simultaneously providing for adequate ventilation.

Efforts should be made to retain the door positions as shown in the drawing. Window positions may be changed according to site specific requirements. The room proportions should be maintained as shown.

R.C.H. PROGRAM

GUIDE TO FACILITIES DESIGN | Drg. No. 1

TYPICAL LAYOUT PLAN FOR SUB -CENTER WITH ANM RESIDENCE



NOTE :
The layout shown integrates the O.T. with the existing facility following the principles of functional consistency. Care has been taken to ensure that the dirty utility remains accessible from outside the building.

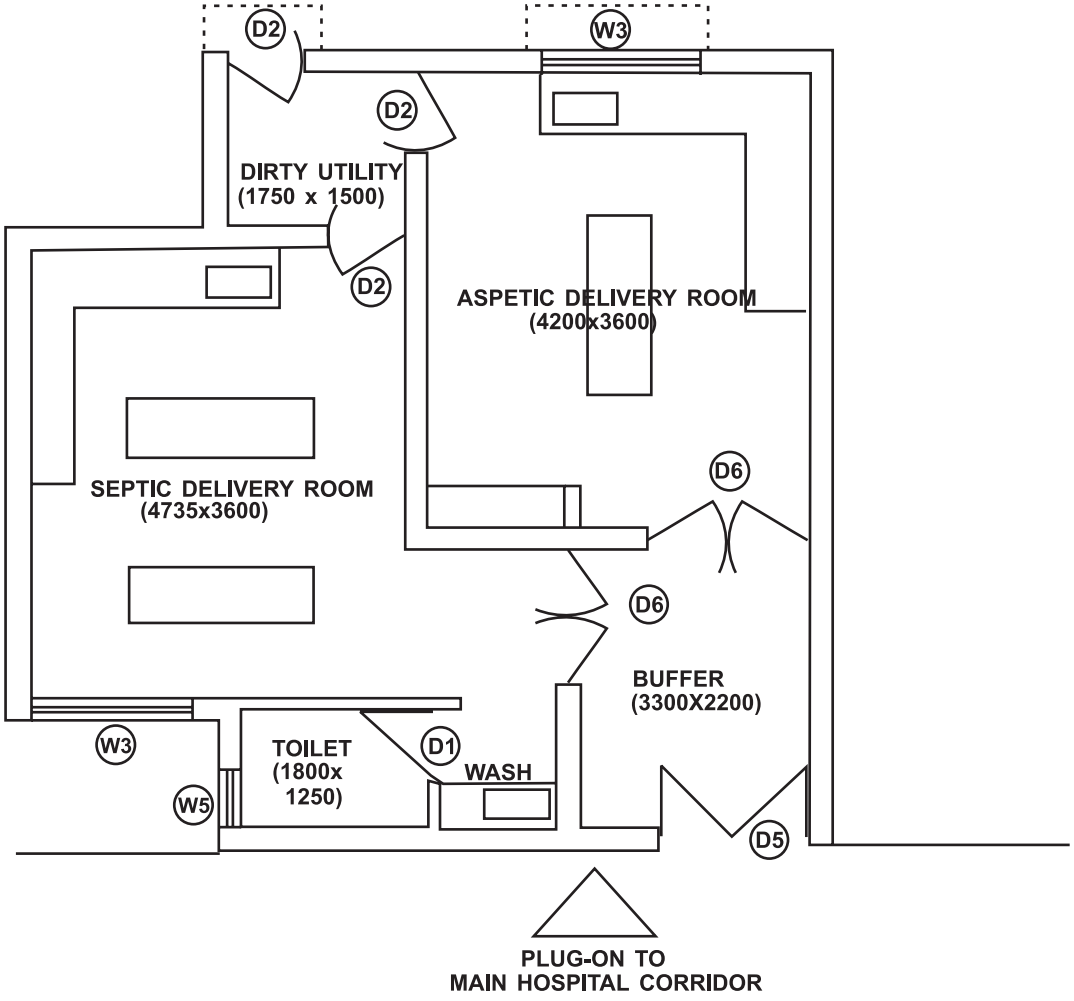
OPERATION THEATRE UNIT
COVERED AREA - 84.00 SQ. MTS.

R.C.H. PROGRAM

GUIDE TO FACILITIES DESIGN
E.C. : PLUG-ON FACILITIES

Drg. No. 2

TYPICAL LAYOUT FOR OPERATION THEATRE



LABOUR DELIVERY UNIT

TOTAL AREA = 55.70 SQ. MTS.

NOTE :

The layout shown here is in the form of a module that would easily integrate itself with the existing facility without jeopardising the functional aspects in any way.

R.C.H. PROGRAM

GUIDE TO FACILITIES DESIGN
E.C. PLUG - ON FACILITIES

Drg. No. 3

TYPICAL LAYOUT PLAN FOR LABOUR ROOM