Handbook

on

Health & Family Welfare
sector investment programme

for

State/ District Programme Managers,
ECTA Facilitators and Consultants

Department of Family Welfare
Government of India &
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GOVERNMENT OF INDIA
DEPARTMENT OF FAMILY WELFARE
MINISTRY OF HEALTH & FAMILY WELFARE
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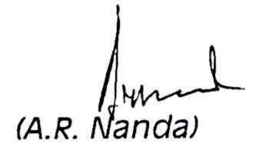
FOREWORD

It gives me pleasure in releasing the Handbook for programme managers for the Government of India – European Commission Sector Investment Programme. The Family Welfare Programme has undergone certain fundamental changes in recent years. We have not only taken a policy decision at the Central and State levels to decentralise the working in this sector and to replace the earlier top down, command-driven approach by the new bottom-up Community Needs Assessment Approach, but the Government is also committed to facilitating real operationalisation of this approach at the district, block and village levels. The Reproductive and Child Health Programme seeks nationwide acceptance of a client driven implementation strategy with full-fledged inter-sectoral coordination and building up partnerships with the NGOs and the private sector at the grassroot level.

The EC is providing substantial grants to the Family Welfare sector. The expectation is that this grant and the technical assistance which goes with it, should help in broadening and deepening the reform process in the health and family welfare sector and also in creating sustainable and replicable models for real and effective decentralisation at the operational level.

This Handbook which has been prepared after indepth consultations with the stakeholders, should help in realising this objective. I am sure the Programme Managers will put this to good use.



(A.R. Nanda)

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Chapter-1: Introduction

A: Sector Investment Programme - An Introduction

In 1996, Department of Family Welfare (DoFW), Government of India (GoI) released its policy document *'The Paradigm Shift'* declaring a shift from the decades old practice of method-specific targets in family planning. This document announced GoI's intention to reformulate its family welfare interventions into a Reproductive and Child Health (RCH) Programme which would seek to introduce a *more decentralised environment*, where the implementing levels of administration would plan and manage with *greater autonomy*, under broad policy guidelines from the Centre.

In 1997, DoFW launched the World Bank assisted Reproductive and Child Health (RCH) Programme. The RCH has been positioned as a major vehicle for implementing the reforms identified in "The Paradigm shift". For instance, resource required for service delivery is sought to be planned on the basis of Community Needs Assessment Approach (CNAA). Similarly, decentralisation is to be promoted through capacity building of the States through setting up of State level training and procurement support agencies and performance based funding will be an area of attention.

The Sector Investment Programme (SIP) seeks to supplement and strengthen the reform initiatives with a view to make the RCH investments more fruitful. In particular, the SIP will seek to:

- Develop, at the State level, the technical skills and relevant inputs for implementing the financial and managerial decentralisation process, including those in terms of managerial structures, infrastructure rationalisation and financial mechanisms;
- Reinforce the organisation and implementation of decentralisation process at district level and below; and,
- Promote attitudinal changes, programming abilities and managerial skills of the decision makers, both at Central and State levels.

> The SIP is an integral part of the National Family Welfare Programme. It will support efforts at bringing about structural, systemic and operational reforms to as to create synergies with the RCH and other Family Welfare schemes and help improving quantity and quality of service on an accelerated pace. The structural, systemic and operational changes undertaken under the SIP may, however, have positive implications for the larger health sector as well.

B: Operational stages for the SIP

- ⇧ Every participating State will set up a Sector Reform Cell (SRC) which will drive and sustain the reform process. The SRC is an arrangement consisting of an empowered body, a secretariat and technical expertise.

  See chapter-2.

- ⇧ Conduct of Policy Reviews will be among the immediate tasks for the SRC.

  See chapters 3 and 7.

- ⇧ Providing support to the participating districts will be another key function of the SRC.

  See chapter-3.

- ⇧ Every participating district will set up a District Health & FW Agency. Structurally, this Agency could be a Society, statutory body, committee, an elected local body etc. Whatever the structure, the District Agency must have sufficient functional and financial autonomy to be able discharge management functions.

  See chapter-4.

- ⇧ Districts and States will make plans for reform and improved programme implementation and management. They will be provided with additional funding to meet the 'cost of change' and to bridge resource gaps in implementing the RCH programme.

  See chapters 3 and 5.

- ⇧ The plans will have a longer term perspective, with more detail for the things to be done in the first year. Thus, the plans for year-1 will 'roll-over' into the next year's plan.

  See chapters 3 and 5.

- ⇧ Continued funding will be subject to satisfactory progress. Progress will be assessed against indicators called benchmarks and all funding will be performance based .

  See chapter-8.

- ⇧ Benchmarks will be part of each plan.

  See chapters 3, 5 and 6.

- ⇧ Every participating State will create a Sector Reform Fund (SRF). The SIP funds to finance State and districts plans will be lodged into the State SRF. The SRF will be non-lapsing and will be kept free of debilitating financial controls.

  See chapter-6.

C: Key ideas for reform

- Encouraging open consideration of the real problems:
  - Treat the underlying causes of poor service delivery, rather than merely the symptoms. This will require a willingness to have open discussion of the potential underlying causes.
  - One way you can demonstrate progress is by showing that everyone now recognises the underlying causes of poor services.
  - You may not be able to deal with them in the short term, but you can at least agree what the problems are. This could be a major step and justify performance-based funding.

- Moving decisions to the right level :
  - Consider whether authority is at the right level. You may find that too many decisions are made too far away from the community. If so, design ways to devolve more authority and responsibility to lower levels.
  - On the other hand, some kinds of decisions may need to be moved to a higher level to avoid duplication or poor co-ordination.

- Community involvement :
  - More involvement will be important in most States and Districts. The community has the right to be involved. Community members can also help changes to be implemented, and they can often suggest better ways than the health workers. Also, this is the only effective way of improving household practices of child bearing and rearing, reproductive health seeking behaviour, promotion of preventive health care etc.

- Integrated service delivery:
  - Services should be integrated, to the maximum extent possible. This means ensuring that each family can get information and services from a single location and health worker, and can be helped to obtain referral or higher level services.
  - Services may need to be re-designed and responsibilities may need to be changed. Also, health workers may need to increase their knowledge and change their attitudes towards clients – to become more client-focused and service-oriented.

- Collaboration across the health system :
  - Collaboration will need to be improved between different levels of the government health system. It will also need to be improved between the government and non-government sectors.
  - Collaboration may mean sharing resources and re-allocating responsibilities. It may also include working together to help provide an integrated set of services.

- Culture and attitudes of health workers:
  - Many of the difficulties are caused by attitudes and working styles of the health workers themselves. They need to be helped to recognise both positive and negative ways of thinking and acting, and to change where appropriate.

- Looking for under-used resources:
  - It is important to make the best use of resources already available, and not simply to try to find more resources. Examples may be staff who could do more if better-trained and motivated, buildings that are being little-used, and so on.

- Sustainability:
  - A change is of little value if it cannot sustain itself. For example, there is no point in constructing a health centre if there will be no guarantee of staff and funds to maintain it.
  - Services are much more likely to be sustainable if they have strong community support. In some circumstances, a service may be more easily sustained if it is possible to raise some continuing funding through user charges.

- User charges:
  - This may be a good way of improving health, if carefully designed. For example, fees raised from people who can afford to pay can be used to provide better services for the most disadvantaged.
  - Effective user charges, however, require that the charging institution has the autonomy to retain and use the collections.

- Prioritisation and a focus of effort:
  - There is a risk that too much will be attempted, and consequently many reforms are started but never finished. You need to prioritise, and you then need to make sure everyone works together to complete the work.

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Chapter-2: Role of State Sector Reform Cell

A: Background

While all stakeholders in the nation's health and family welfare sector are agreed on the need for sector reform and its direction, no reliable institutional arrangements exist in a majority of the States for driving and sustaining the reform process. In the absence of such an arrangement, reform tends to become a series of individual initiatives, sporadic in nature and fragile.

Realising the need, the Sector Investment Programme (SIP) mandates creation of an institutional arrangement for driving the reform process. The stipulation about the mechanism, named the ' State Health and Family Welfare Sector Reform Cell', is as follows:

> "Each of the non-SHS participating States will create or so designate an existing body as the *State Health & Family Welfare Sector Reform Cell.* This Cell will have the mandate, authority and autonomy to drive the sectoral reform process and to take all actions necessary in pursuance of that objective. The SH&FWSRC shall be chaired by the Principal Secretary or Secretary in overall charge of the H & FW Sector of the State. It is recommended that this Cell acquire management expertise in areas like health economics and management information systems, by appropriate consultancy arrangements.........."

B: Why Sector Reform Cell ?

In the Government, decisions on major policy issues are generally taken by the political executive after a thorough examination of issues; analytical reporting of status and causative factors and formulation of feasible options/alternatives etc. The nature of the consultations may be legislative (i.e. consideration by a legislative committee), or statutory (i.e. publication of draft for public reaction), or administrative (e.g. consideration by an administrative body or by a technical committee), or even informal (e.g. meetings with interest groups). Whatever may be the mechanism, the decision making process, particularly relating to policy changes, must be backed by well-articulated options with adequate analytical support. The Government Department concerned needs enhanced capacity to be able to focus upon and steer the reform process in its respective sector. The Sector Reform Cell (SRC) aims to provide this enhanced capacity within the department concerned.

C: What is the Sector Reform Cell ?

The SRC is additional capacity of the State Department of Health & FW for generating, prioritising, advocating and assessing reform proposals in the health & family welfare sector across the State. Reforms would cover State-wide as well as district-specific aspects/activities, including donor supported activities.

D: What the Sector Reform Cell is not

The Sector Reform Cell is not an academic or research institution, but will provide technical and secretariat support within the State Department of Health & FW. Although the Cell will

need a degree of autonomy to reconsider existing structures and systems, it need not be an autonomous society, unless it is also to serve as a mechanism for flow of funds. The Cell should not be a new body if another mechanism already exists which can carry out the functions described here - or one can be given extended powers and/or membership to carry out those functions. States where there are or will be World Bank SHS Project are expected to have a Strategic Management body, and to avoid duplication, the two functions could be merged in a single body.

E: Components of a Sector Reform Cell

The Cell will consist of :

(a) an empowered committee / board / council / bureau to direct and oversee the reform activities;
(b) a secretariat; and,
(c) dedicated or hired technical expertise and capacity.

As explained below, these functions may overlap, depending upon the choices made by the State.

E-1: Empowered body : The Committee / Board / Council (the name does not matter) will, among other things:

- ❑ receive proposals for policy reforms,
- ❑ establish priorities for analysis or implementation,
- ❑ agree modalities for carrying out analysis,
- ❑ agree implementation strategies,
- ❑ allocate funds,
- ❑ monitor and evaluate reforms against anticipated results, and
- ❑ advocate changes with other stakeholders.

Membership of the empowered body will depend on function. Who needs to be on the Committee / Board / Council for it to be credible and powerful enough to succeed? To be successful, it will probably need to include, besides Health and Family Welfare officials, a number of stakeholders: representatives of other Governmental departments, professional bodies, key institutions, district representatives, donors, NGOs, private sector, consumer activists or forum etc.

E-2: Secretariat: The Empowered Committee will need secretarial support to keep records of meetings, co-ordinate activities, follow up on decisions, etc. The Secretariat can be either of the following:

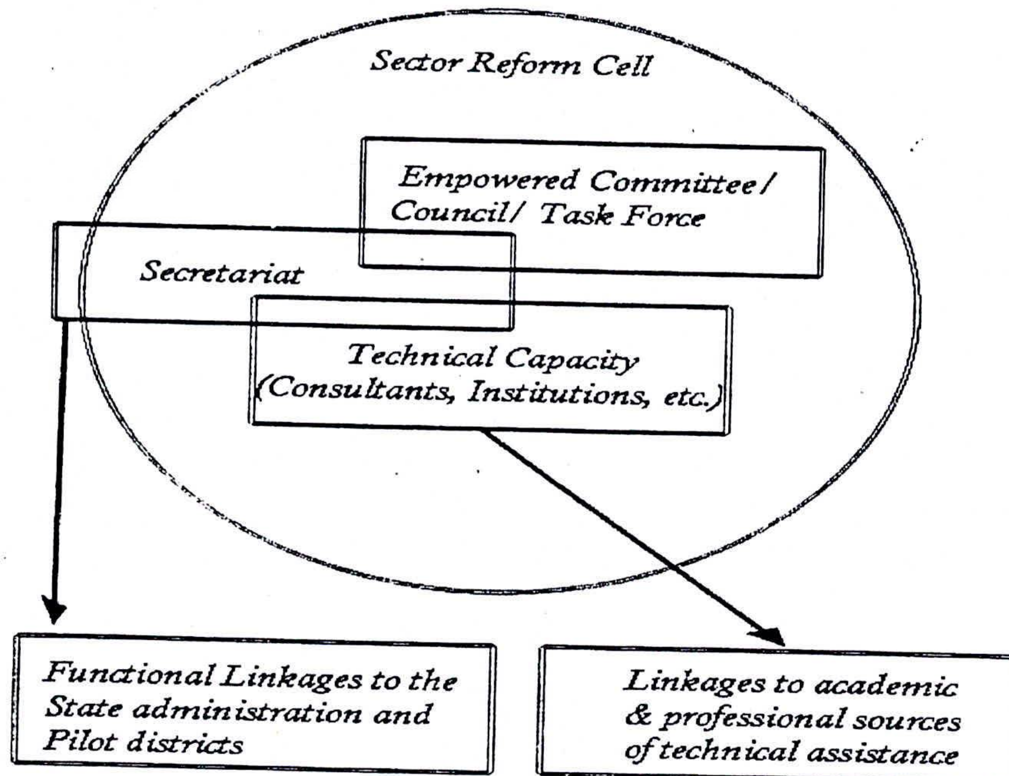
- ❑ One or more consultants or an institution;
- ❑ A member of the administration on deputation to this role;
- ❑ A member of the administration combining this responsibility with another regular role sufficiently related to mean that it gets proper attention;
- ❑ A combination of the above.

E-3: Technical expertise and capacity: The Empowered Body and Secretariat will need to use technical specialists, among other things, to:

- carry out or commission studies of various sorts;
- review literature;
- design and carry out pilot projects;
- participate in policy assessment;
- formulate new measures; and,
- carry out monitoring and evaluation.

Technical capacity to perform the above functions can be acquired in several ways:

- some technical specialists may be on the empowered body itself;
- some may be recruited part time or full time for the Secretariat for general purposes;
- some institutions and/or consultants may be recruited or contracted for specific activities and studies;
- subcommittees or task groups of technical people may be established to take responsibility for specific components of the overall activities.



The diagram given above separates out these three discrete functions, but it will be seen that there are likely to be overlaps e.g. a consultant could be hired to assist with the secretariat, could carry out activities as part of the technical capacity and be a member of the empowered body at the same time .

The Cell is not just a 'think-tank' of the State; it has to be involved in the entire range of policy and operational reforms in the State, both for health as well as family welfare schemes on the one hand and internally financed as well as externally assisted schemes and

programmes on the other. Though the Cell is supported financially and technically by the SIP, its jurisdiction and functions are sector-wide, not confined to SIP.

F: Immediate tasks for the SRC:

In the context of preparation of State's SECPIP and preparation of plans for the demonstration districts, however, the Cell's immediate tasks would include the following:

- Undertake or commission policy reviews and policy research, including associated studies and surveys. For some of these, help may need to be taken from outside agencies (e.g. for resource mapping in the districts). The Cell will identify all such tasks and would prepare the Terms of Reference under which the identified tasks are to be contracted out.
- Prepare Year-1 SECPIP. Preparation of SECPIP need not wait for the policy reviews to be completed; the States can take up any policy or operational reform activities which may have a potential for improving the delivery of services[1]. The Cell, in this regard, is expected to identify the new activities that could be taken up. These could include (a) new activities that could be taken up on a State-wide basis; (b) felt needs that are not met from any other source; and (c) operational research and / or pilot activities[2].
- Preparation of detailed activity plans and budgets for activities/interventions included in Year-1 SECPIP.
- Provide technical support and guidance to the district Agency/Society and district programme managers in the formulation and implementation of district action plans (DAPs).
- Review the achievement of benchmarks by districts and release funds against benchmarks achieved.
- Develop an agenda and priority list for policy changes as an outcome of the policy reviews; formulate appropriate policy documents; and provide technical support for approval at various levels in the government.
- Prepare a comprehensive SECPIP, based on the inputs from the policy reviews, indicating the agenda and plan of action for operational and policy reform in the State[3].
- Encourage and enable every member of the Department / Directorate to contribute to system reform, through dissemination of information and analysis, and participatory processes for policy formulation.

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[1] Govt. of Himachal Pradesh, for instance, issued a Notification in November, 1999, announcing functional integration of department of Indian Systems of Medicine with Department of Health & Family Welfare for the purpose of implementation of RCH and other national programmes in the State. In the same month, the State Govt. also issued a Notification announcing delegation of administrative and financial powers, applicable on a State-wide basis.

[2] Govt. of Himachal Pradesh have launched a 'quality assurance' scheme on pilot basis in three city hospitals. The scheme seeks to ensure greater accountability of the doctors and other serving staff toward patient care through a feedback system. The feed back would be analysed by the Superintendent of the hospital for taking remedial measures to improve the functioning of the institution.

[3] The year-one SECPIP, as mentioned, would only have been prepared on the basis of felt needs of the State and, therefore, may have only have a limited reform agenda, pending completion of the policy review exercise.

G: Future Tasks of the SRC:

Some of the key tasks that the Cell will need to undertake in future are described below. The States may add to or modify these, depending on the State-specific conditions.

Policy Analysis: Go beyond the issues covered by the four Policy Reviews and look at the entire spectrum of policies, procedures, structures, strategies, practices, organisational culture, resourcing, provider capacity, quality of services, cost-effectiveness of different items of service, distribution of services against user demand in case of private goods and distribution of public and merit goods according to user needs, and finally, the most critical element in service delivery: consumer satisfaction.

Policy Formulation: Identify the domains for action for health sector reform at systemic level to ensure equity, at programmatic level to achieve allocative efficiency, at the organisational level to improve productivity and technical efficiency, and at the instrumental level for performance enhancement and human resource development. Advise the health planners to prioritise the reform agenda within the framework of overall resource availability and design alternative financing mechanisms to broaden resource base.

Systems analysis and development: Assess the progress of systemic changes included in the SECPIP and suggest mid-course corrections. Prepare further systems development/improvement plans. Provide support, where necessary, in the testing, evaluation and integration of new systems. Quantify and present the savings accruing to the public exchequer and to the community, as a result of policy reforms initiated at its instance.

Management information systems development and integration: Assess the information needs of programme managers and supervisors at various levels and develop/upgrade information collection, analysis, response and feedback systems to improve overall programme management. Provide the necessary technical expertise to integrate the newly developed systems with the operational divisions and partner programmes/ initiatives.

Behavioural and attitude change management; advocacy support mobilisation: Undertake advocacy measures for public acceptance of new policies. Plan and support interventions to improve work attitudes of health functionaries.

Operational research, pilots, their documentation and dissemination: Undertake or commission operational research and / or pilot activities on an on-going basis. Document and disseminate the results of such initiatives, for possible replication.

H: Costs and Budget

The investment and operational costs of the Cell and associated committees etc. can be debited to the EC supported SIP for the duration of the SIP. The operational cost of the Cell can be shown in the indicative budget for the SECPIP (see Chapter-3: Guidelines for preparing SECPIP for more details).

I: Terms of engagement of experts and institutions

States may decide to engage a consultant or an institution to provide the secretarial or technical support to the Cell or for carrying out such tasks as may be decided by the Cell. States are encouraged to evolve their own terms of reference for engaging consultants and/or institutions. It is suggested that the services are hired on contractual basis, with a limited period of engagement. Remuneration packages may be decided in consonance with the guidelines / instructions circulated in connection with engagement of RCH consultants. In case of any difficulty, reference may be made to the PMB.

In the case of engagement of individual experts, the names and CVs of persons selected may be sent to Joint Secretary (RCH), Department of Family Welfare, with a copy to the EC Technical Asistance (ECTA) Team. Either GoI or ECTA Team may convey their objection/reservation in writing within two weeks, failing which their concurrence will be assumed.

J: Support Staff for the SRC:

The number and cost of support staff shall be kept to the absolute minimum. Hiring may be on contractual basis (annual with provision for extension after performance review). No vehicle shall be purchased for the Cell. Any need for mobility shall be met by hiring of vehicle, either on trip basis or monthly basis.

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Chapter-3: Guidelines for preparing Year-1 State EC Programme Implementation Plan (SECPIP)

A: Introduction

The districts will evolve their own reform plans, with more details about the things to be done in year-1. The district plans, thus, will have a longer term perspective, but the specific activities towards achieving the plan objectives will have a one-year focus so that the activities to be taken up in year-2 can take note of successes achieved and obstacles experienced in the previous year. In other words, the plans for the previous year will 'roll over' into the next year's plan. (See Chapter-5: Guidelines for preparing District Action Plan).

A similar approach is suggested for the SECPIP. It is recognised, however, that a clearer perspective for the reform programme in a State will emerge only after the policy reviews have been completed. As such, the agenda for year-1 SECPIP has been determined before hand.

B: SECPIP Focus in year-1

The Sector Investment Programme (SIP) envisages that the States' year-1 SECPIP will consist of the following:

- Reform activities which States may wish to take up on their own initiative, without waiting for the outcomes of the policy reviews (e.g. the Order issued by Govt. of Himachal Pradesh announcing integration of ISM and delegation of financial and administrative powers – see footnote-1 to Chapter-2: Role of State Sector Reform Cell). Such initiatives, which may or may not involve an expenditure, could be included in year-1 SECPIP.
- Plan of action for the Policy Reviews, indicating (a) who will do what, (b) the time schedule, and (c) the cost.
- State-wide activities which a State feels are necessary for improving the delivery of services, but can not be taken up because funds are not available from other sources.
- 'Pilots' to test one or more 'ideas' aimed at improving the delivery of services.
- Technical assistance and policy support to the SIP districts.

All of the above, taken together, will constitute the year-1 SECPIP. After the outcomes from the policy reviews are available, year-1 SECPIP will 'roll-over' into year-2 SECPIP.

C: Minimum Contents of the SECPIP proposals

Ideally, details for all of the above should be included in the year-1 SECPIP proposals. However, a State may not be ready with the proposals for all and it may only delay the year-1 SECPIP if the Programme Management Bureau (PMB) insisted to have a proposal on all of them. It has, therefore, been agreed that year-1 SECPIP proposals can be submitted in parts. For example, if the plan of action for the Sector

Reform Cell (SRC) has been prepared and arrangements for the policy reviews have been finalised, they can be sent to the PMB for approval. The proposals for pilots and State-wide activities can be submitted subsequently.

> Addition of a component later in the year will involve (a) revision to the list of benchmarks (including, if necessary, the values assigned to them) and (b) re-calculation of funds requirement for the revised SECPIP. Such revisions may be time consuming both for the State as well as the PMB. Therefore, it is advisable that the initial proposals as comprehensive as possible.

The first set of year-1 SECPIP proposals must have the following:

C-1: Situation Analysis:

- Mortality and morbidity pattern in the State.
- Description of Family Welfare, MCH, CSSM, RCH and related projects completed in the last five years or ongoing in the State and their impact on the mortality and morbidity situation.
- On-going Family Welfare, MCH, CSSM, RCH and related projects. Indicate how they relate to mortality issues across the districts and problems specific to areas having higher incidence of mortality.
- Donor specific project information – geographic area covered, project objectives, components, duration, and financial outlay.
- Utilisation of inputs in the recent past (say, in the three financial years, including 1999-2000). Indicate sanctioned financial outlay, financial outlay utilised, and reasons for shortfall in spending / achievement and other related information.
- Reasons for shortfalls. Outline problem caused by policy, systems, norms and procedures which are felt to be coming in the way of effective programme implementation in the State.

> Exhaustive details are not necessary, but all the above elements must be included. This will help appraisal of the proposals included in the SECPIP.

C-2: Year-1 agenda for the SRC:

- The Government Order / Resolution constituting the SRC giving details of members, areas of expertise and nature of association with the SRC, such as ex -officio, part time, full time, on deputation, contractual etc.
- Terms of reference of the SRC.
- Agreed first year work priorities of the SRC with detailed year-1 work plan .
- Estimates of incremental operational expenses of the SRC giving basis of estimates (please do not include salaries or other costs already being met from on going programme/project funds). [As mentioned in Chapter-2, the SRC is an arrangement rather than a separate body by itself. However, depending upon the choice made for the 'arrangement', funds may be needed to meet the operational costs of the SRC. For example, costs may be

involved when the SRC hires individual experts / consultants to work full or part time for the SRC or for providing technical assistance to the SIP district on behalf of the SRC.]

C-3: Policy Initiatives proposed: Indicate policy initiatives undertaken or proposed to be undertaken by the State on its own, particularly with reference to the problems experienced in the implementation of existing schemes/programmes. For the proposed initiatives, indicate if any technical and / or financial assistance is needed. In other words, policy initiatives which do not require financial assistance should also be included. These, in fact, can be proposed as benchmarks to obtain funds for the SECPIP components (see example component 4 in Appendix to this chapter).

C-4: Policy Reviews: Indicate how the policy reviews are proposed to be conducted. Include the following for each policy review:

- Final ToRs of the Policy Reviews proposed to be undertaken in the State.
- Details of the task forces set up within the Department for conducting each review.
- Time schedule for carrying out each of the reviews.
- Scope and methodology proposed to be adopted for each review.
- Details of tasks to be contracted out, indicating agency/institution/individual selected for each such task.
- Estimated expenditure for each review, including the basis of calculation.
- Measurable indicators proposed to be used for monitoring progress of each review.
- Proposed mechanism for using the results of reviews for improvement in policy, systems, procedures and norms.

D: Proposals that could be submitted at any stage:

D-1: Felt needs, not covered elsewhere: Activities (these can even be State-wide) which are proposed to be taken up under the SECPIP. Only such activities may be included for which no funds are available from any other existing source or, if available, they are not sufficient.

D-2: Pilots : Include the pilots that are proposed to be undertaken.

E: State's role in the implementation of District Action Plan (DAP)

The PMB has decided that the funds needed for the implementing the DAP in the districts included in the SIP will be channeled through the State Sector Reform Fund (SRF) and the task of releasing funds to the districts will be handled at the State level. However, the State will have to 'earn' the funds for DAPs through a set of benchmarks demonstrating the technical assistance and policy support provided to the districts in the implementation of the DAPs. Accordingly, immediately after approval of a DAP by the PMB, the State will have to prepare and submit its plan for supporting the DAP. This will constitute a separate Component of the SECPIP (see example component 4 in Appendix to this chapter).

F: Formats to be used for presenting SECPIP proposals

To facilitate quick review and also to ensure that all essential details for review are included, SECPIP proposals should be prepared in a three-part format, called Component Management Protocol.

The Year-1 agenda for the SRC, each of the policy reviews, each of the State-wide activities, each of the pilots proposed and every policy initiative will constitute a 'component'. Management of DAP for each of the SIP districts will also constitute a component.

For each component, the 'Component Management Protocol' will have the following three parts:

- Part-I: 'Component description'. As the name suggests, this is nothing but a description of the Component. For instance, if the component relates to year-1 agenda for the SRC, the summary will be with reference to the points mentioned under sub-section-II of Section C above.
- Part-II: 'Time Schedule'. This is to be prepared as a Gantt chart for all the activities to be undertaken under the component.
- Part-III: 'Cost estimates', including the basis of cost calculations.

To facilitate reference, the Components should be serially numbered.

G: Illustrative examples

Four illustrative examples are given in Appendix to this chapter : one for SRC action plan (Component-1, all parts), one for a policy review (Component-2, parts-I and II only), one for DAP management (Component-3, parts I and II only), and one for a policy initiative which does not require any financial assistance (part-I only). These may be used to formulate these components of the SECPIP. For all other components of the SECPIP, formats will be the same as shown in the illustrative components for the district action plan.

As will be observed, formats for SRC action plan, policy review, DAP management and policy initiatives are slightly different than those for the pilots, state-wide activities and policy initiatives of the SECPIP. Formats for the latter are exactly same as for the district action plan components. The changes are as follows:

- items for component description (part-I of component management protocol) for SRC action plan, policy reviews, DAP management, and policy initiatives are different (see examples in Appendix to this chapter and those in Appendix to Chapter-5: Guidelines for preparing District Action Plan);
- the time schedule (part-II) for these do not go beyond 2000-01 because (a) the SRC agenda and DAP management plan will be sought on an annual basis, (b) policy initiatives have either been taken or would be taken well within year-1, and (c) the policy reviews are expected to be completed within year-1.

H: Benchmarks

States will have to negotiate two sets of benchmarks with the PMB:

- the benchmarks related to Components constituting the State plan proper, i.e. the SRC agenda for year-1, policy initiatives, policy reviews, pilots and State-wide activities; and
- benchmarks related to the management of and support to the DAP. [DAP related benchmarks in the State Plan will naturally be broader in scope than the benchmarks in the DAP itself (see example component-4 in Appendix to this chapter).]

Approval of SECPIP by PMB will be the first benchmark for State plan proper. The State will have to determine the value of this 'trigger' benchmark on the basis of funds required for implementing the SECPIP activities until the funds linked to the first benchmark derived from the SECPIP components become available.

Similarly, 'approval of DAP by PMB' will also be an automatic benchmark and will 'trigger' release of a part of year-1 outlay for the DAP. The State will have to indicate, at the time of forwarding the DAP, the amount that should be released by PMB on approval of the DAP. These funds will be lodged in the State's Sector Reform Fund (SRF) and released in full to the district.

Additional funds for SECPIP proper components will be released upon achievement of benchmarks derived from them.

Additional funds for the DAP (along with any requirements of the State for the activities relating to management of and support to DAP) will be linked to the benchmarks set by the State for itself in this regard (see example component 3 in Appendix to this chapter). These will be lodged in the SRF and released to the district upon the achievement of benchmarks derived from the DAP.

I: Assigning values to benchmarks

After the component details have been prepared, a set of benchmarks are to be derived from these. Then, appropriate values are to be attached to them in such a way that their achievement will provide enough funds to ensure that there are no funds shortages at any time during implementation phase (see section E.5 of chapter-8 for more details).

The value attached to each benchmark would be related generally to sustainable impact the connected activity has on health status. The value of a benchmark may, therefore, not have any relation to the cost of the connected activity. For instance, a construction activity may have a high cost. However, since the health benefit from the construction would be indirect and would take long in coming, a benchmark related to civil works should have a lower value than one related to, say, improving immunisation coverage.

Following operational steps are suggested for assigning values to the benchmarks:

- list the benchmarks in the following format (see next page), leaving the values column blank:

List of benchmarks						
Sl. No.	Benchmark description	Related Component		Expected month of achieving	Value attached Rs. Lakh	Indicator of achievement
		Com. No.	Com. Description			

- Next, summarise the expenditure estimated to occur in each quarter of the year 2000-01 for all components included in your plan for year 2000-01. Include the district requirement also, if the relevant DAP management is one of the components of the proposals. Use the following format:

Funds needed for implementing components					
Compo nent No.	Component description	Funds needed in year 2000-01			
		April-June	July-Sept	Oct-Dec.	Jan-March
Total requirement for all components					

- Now, determine the values to be assigned to the benchmarks in such a way that the total expected receipts for each quarter cover the total expected expenditure. However, do not try to draw funds far in excess of the need. The money sitting idle in one place may deprive another of funds.

> If an additional SECPIP component is proposed (this may happen when the State submits a new component on pilots, State-wide activities or policy initiatives), a *revised* benchmark list for the SECPIP as a whole will have to be prepared and submitted along with the component management protocols for the additional component(s). The revision may be on account of adding new benchmarks derived from the additional components or on account of changes in the values assigned to the existing benchmarks, or both.
>
> When a DAP is approved by PMB, the State will submit its plan for supporting it as an additional Component of SECPIP. In this case, there will always be an additional set of benchmarks.

****

Appendix to Chapter-3
Examples of SECPIP components

Sector Investment Programme
Component Management Protocol

Part-I: Component Description

Implementing Agency : State ABC

Component Number	1	Component Title	SRC agenda for year 2000-01

Composition of the SRC	Govt. have set up a task force under the Chairmanship of Principal Secretary (Health) for developing a health and family welfare vision document for the State and to prepare the agenda for policy reform. This task force will also be responsible for monitoring implementation of policy reform. The terms of reference of the Task Force are enclosed. A special unit has been set up in the State Health & Family Welfare Institute to function as the secretariat for the Sector Reform Cell. An Officer, drawn from the State administration, with previous experience in the sector, has been selected to work as Secretary to the SRC. She will be assisted by a team of doctors placed in the SRC secretariat on deputation basis and experts hired in the areas of (a) change process management, (b) health financing, and (c) communication for behaviour change. A copy of the Order creating the SRC Secretariat is enclosed. A rate structure for hiring of experts as consultants has been approved for the State and henceforth all consultants under various programmes and schemes will be hired accordingly.
Priorities for year-1	▪ Undertake/commission the policy reviews. ▪ Share the outcomes of the policy reviews with the programme managers with a view to evolve an agenda for policy changes. ▪ Develop a perspective for the SECPIP, based on the outcomes of policy reviews and reflecting State priorities. ▪ Prepare SECPIP action plan for year 2001-02. ▪ Assist the SIP districts in formulating, implementing and monitoring their reform plans. ▪ Undertake capacity building measures for district programme managers. ▪ Undertake pilots of innovative approaches. ▪ Undertake policy reform measures based on policy review outcomes.
Activity Plan for the year	This is given in Part-II for this component.
Financial assistance needed for SRC activities in the year	Rs. 30.50 lakh (as per details given in Part-III) [Cost of policy reviews and technical support to SIP districts are shown under relevant components.]
Benchmark(s) derived from this component	Policy reviews commissioned. Value: Rs. 35.00 lakh. Policy reform measures announced. Value: Rs. 30.00 lakh. SECPIP plan for 2001-02 approved. Value Rs. 25.00 lakh

EC-GoI Sector Investment Programme
Component Management Protocol
Part-II: Time Schedule for the Year 2000-01

Implementing Agency: State ABC

Component Number: 1 | Component Title: SRC agenda for year 2000-01

Sl. No.	Activity description	Months (April, 2000 to March 2001)											
		A	M	J	J	A	S	O	N	D	J	F	M
1	Policy review on work force management (further details are given in part-II for this component).		—	—	—	—							
2	Policy review on delineation of roles and responsibilities (further details are given in part-II for this component).		—	—	—	—							
3	Policy review on rational use of infrastructure (further details are given in part-II for this component).			—	—	—	—						
4.	Policy review on performance based funding options (further details are given in part-II for this component).			—	—	—	—						
5	Workshops for sharing outcomes from policy reviews						—	—					
6	Developing a perspective for SECPIP							—	—				
7	Preparation of SECPIP for year 2001-02									—	—		
8	Capacity building: management training for district programme managers								—	—	—		
9	Assisting SIP districts in formulating, implementing and monitoring their reform plans	—	—	—	—	—	—	—	—	—	—	—	—
10	Undertake policy reform measures based on policy review outcomes.								—				

EC-GoI Sector Investment Programme
Component Management Protocol
Part-III: Cost Summary

Implementing Agency: State ABC

Component Number	1	Component Title	SRC agenda for year 2000-01

Expenditure category	Expenditure (Rupees in lakh) estimated to occur in 2000-2001				
	April-June	July-Sept.	Oct.-Dec.	Jan- March	Total
A: Non-recurrent Costs					
Civil works including renovation	---	---	---	---	---
Vehicles	---	---	---	---	---
Medical Equipment	---	---	---	---	---
Non-medical equipment including	---	---	---	---	---
Training and workshops	---	1.00	2.50	0.50	4.00
Consultants' fees	---	---	6.00	---	6.00
Other non-recurrent costs	---	---	---	---	---
B: Recurrent costs					
Contractual staff payments	4.00	5.50	5.50	5.50	20.50
Health consumables	---	---	---	---	---
Non-health consumables	---	---	---	---	---
Vehicle maintenance including POL expenses	---	---	---	---	---
Building maintenance	---	---	---	---	---
Other recurrent costs	---	---	---	---	---
Total for the component	4.00	6.50	14.00	6.00	30.50

Calculation Norms for Component Number-1

A: Workshops:

- Number of workshops : 2
- Number of participants per workshop : 40
- Duration of each workshop : 2 days
- Timing : September, 2000 and October, 2000
- Cost per workshop:
  - Workshop material : Rs.10,000/-
  - TA/DA for participants : Rs.60,000/-
  - Working lunch: Rs. 5,000/-
  - Venue, documentation and other expenses: Rs. 25,000/-
  - Total : Rs. 1.00 lakh per workshop

B: Management training for district programme managers

- Number to be trained : 100
- Location: Institute XXX in 4 batches of 25 each.
- Timings: 1 batch in November, 2000, 2 batches in December, 2000 and 1 batch in January, 2001
- Cost per batch: Rs. 2.00 lakh
  - payment to the institute : Rs. 1.50 lakh (including boarding and lodging)
  - TA/DA to participants : Rs. 50,000/-
- Payment timings for the Institute : Rs. 3.00 in Oct.2000 and Rs. 3.00 lakh in December, 2000.)
- The TA/DA allowances will be paid separately in the months of training.
- Payment to the Institute has been included under "consultants' fees" category. The TA/DA to be paid to the medical officers has been placed under training costs.

C: Contractual staff payments

- Three experts @ Rs. 50,000 per month, starting from May, 2000.
- Other secretarial assistance @ Rs. 1.00 lakh per quarter.

Please note

In case of items to be procured, supporting documentation reflecting prevalent market rate should invariably be attached.

Sector Investment Programme
Component Management Protocol

Part-I: Component Description

Implementing Agency : State ABC

Component Number	2	Component Title	Policy review on workforce management
Key terms of reference for the review		[summarise the ToRs as adopted. If no changes were made to the ToRs provided by DoFW, mention so.]	
Methodology for the review		A task force has been set up to conduct the review.	
Tasks to be contracted out		No task has been contracted out. However, a team of experts has been identified to assist the Task Force. The CVs of the experts are enclosed.	
Time schedule for the review		This is given in Part-II for this component.	
Estimated expenditure		Rs. 20.00 lakh.	
Benchmark(s) derived from this component		Field work commenced. Value: Rs. 10.00 lakh. Report finalised and submitted to the SRC. Value: Rs. 15.00 lakh	
Mechanism proposed for using the results of the review		Results of the review will be used by the SRC for undertaking policy reform measures.	

EC-GoI Sector Investment Programme
Component Management Protocol
Part-II: Time Schedule for the Year 2000-01

Implementing Agency: State ABC

Component Number	2	Component Title	Policy review on workforce management

Sl. No.	Activity description	Months (April, 2000 to March 2001)											
		A	M	J	J	A	S	O	N	D	J	F	M
1	Development of methodology and study tools, including literature review		—										
2	Data collection and field work			—	—								
3	Interim report preparation					—							
4.	Presentation of interim report					—							
5	Final report preparation					—							

<table>
<tr><td colspan="2">Sector Investment Programme
Component Management Protocol

Part-I: Component Description

Implementing Agency : State ABC</td></tr>
<tr><td>Component Number: 3</td><td>Component Title: Management of and support to DAP for district XYZ</td></tr>
<tr><td>Technical assistance / Policy support needed for the DAP.</td><td>• State GO empowering district Agency / Society to determine and decide rules / norms for deployment of medical and para-medical staff, including withdrawal of specialists from identified CHCs/PHCs to sub-divisional hospitals.
• State GO enhancing delegation of financial powers, including maintenance funds.
• State GO allowing the district Agency / Society to determine and introduce user charges.
• Central Govt. orders allowing the district programme managers to shift non-salary funds under Centrally Sponsored Schemes from one sub-head to another (within same head).
• Technical assistance for conducting a work and motion study in the district.</td></tr>
<tr><td>Funds requirement</td><td>A: For the DAP – Rs. 150.00 lakh
• 1st Quarter: Rs. 30 lakh
• 2nd Quarter : Rs. 30 lakh
• 3rd Quarter : Rs. 40 lakh
• 4th Quarter : Rs. 50 lakh
B: For providing technical assistance – Rs. 5.00 lakh (consultancy fee to research institution PQR for providing technical assistance to the district for the time and motion study).
C: Total – Rs. 155.00 lakh</td></tr>
<tr><td>Time schedule for the policy support activities</td><td>This is given in Part-II for this component.</td></tr>
<tr><td>Benchmark(s) derived from this component</td><td>State GO on deployment of medical / para-medical staff is issued. Value: Rs. 30.00 lakh
GO on enhanced delegation of financial powers issued. Value: Rs. 40.00 lakh
GO, empowering district Agency / Society to introduce user charges, issued. Value: Rs. 50.00 lakh</td></tr>
</table>

Note: It is assumed that the 'trigger' benchmark (linked to approval of DAP) had a value of Rs. 50.00 lakh.

EC-GoI Sector Investment Programme
Component Management Protocol
Part-II: Time Schedule for the Year 2000-01

Implementing Agency: State ABC

Component Number	3	Component Title	Management of DAP for district XYZ

Sl. No.	Activity description	Months (April, 2000 to March 2001)											
		A	M	J	J	A	S	O	N	D	J	F	M
1	Issue of GO on deployment of medical / pare-medical manpower												
	⊕ receive proposal		X										
	⊕ SRC examines the proposal and obtains necessary approvals			X									
	⊕ GO is issued				X								
2	Issue of GO on enhanced delegation of financial powers												
	⊕ receive proposal		X										
	⊕ SRC examines the proposal and obtains necessary approvals			X									
	⊕ GO is issued				X								
3	Issue of GO empowering district Agency / Society to introduce user charges												
	⊕ receive proposal			X									
	⊕ SRC examines the proposal and obtains necessary approvals				X								
	⊕ GO is issued					X							
4	Engage an expert agency / institution to provide technical assistance to the district for conducting work and motion study												
	⊕ identify the agency / institution	X											
	⊕ receive, examine and approve study tools		X										
	⊕ observe and review the field work			X									
	⊕ participate in the dissemination of results				X								
	⊕ assist the district in streamlining MIS in the district					X							
5	Obtain Central Govt. orders allowing concurrence the district programme managers to shift non-salary funds under Centrally Sponsored Schemes from one sub-head to another.												
	⊕ send proposal to DoFW		X										
	⊕ obtain the Order			X	X								

Sector Investment Programme
Component Management Protocol

Part-I: Component Description

Implementing Agency : State ABC

Component Number	4	Component Title	Policy initiatives
Brief description of the policy initiatives		• Integration of Indian Systems of Medicines. • Policy framework for certification / grading of hospitals in the public and private sectors. • Policy framework for contracting out support services in the public sector hospitals. • •	
Perceived benefits / impact of the policy initiatives proposed		▪ Improvement service delivery. ▪ Involvement of policy framework. ▪ ▪ ▪	
Activity Plan for the year		This is given in Part-II	
Financial assistance needed for SRC activities in the year		None	
Benchmark(s) derived from this component		• GO on integration of ISM issued. Value: Rs. 15.00 lakh • Policy framework on grading / certification released. Value Rs. 20.00 lakh • 50% of public sector hospitals assessed for grading. Value: Rs. 15.00 lakh. • Policy framework on contracting out of support services at public sector hospitals released. Value: Rs. 40.00 lakh.	

Chapter-4: Role of District Health & Family Welfare Agency / Society

Background

Starting with the District Rural Development Agencies (DRDAs) in the late 1970's, a number of district level agencies have been set up by various donor-assisted and domestically funded programmes. Mainly, these societies have functioned as entities facilitating the flow of funds, relatively free of the rigid Governmental financial procedures.

A multiplicity of such agencies have begun operating in the health and family welfare field as well, in response to demands from GoI and donors for easier and smoother flow of funds. Typically, the societies have been formed according to the vertical programmes they service. Also, with the exception of the SIFPSA in Uttar Pradesh, these societies do not have much management or technical skills or expertise.

Experience indicates that a multiplicity of such 'shell' societies, all of which rely on the same public sector health delivery infrastructure, creates internal contradictions and fragments effort. Since much of the official membership is common, there is also no logic in preserving the independent identity of these societies.

The SIP, therefore, envisages that an integrated 'District H & FW Agency' would be set up in each of the demonstration districts. This agency will be expected to plan and manage local services according to the CNAA planning and resources available to it. It may receive on-going consultancy and institutional support, and be granted special status by the State Government in regard to identified and agreed areas of authority and expenditure.

In other words, the *district agency will be expected to discharge management functions rather than being a mere funds-flow mechanism.*

Is there a 'recommended' model ?

It is not recommended that an additional society be set up.

Nor is it recommended that all districts create an identical structure. Following considerations, however, should guide the organisational set up for the district body:

- The agency will be responsible for managing all health and family welfare programmes in the district.
- The agency will also have to create conditions conducive to involving the private sector as well as the NGOs present in the district.
- It may have to generate additional resources to supplement those available from the State and Centre.
- It must have sufficient decision making powers (e.g for recruitment and deployment of staff, introduction of cost recovery measures, procurement of emergency drugs, construction and maintenance of health facilities etc.).

- It should have sufficient representation from the community (e.g. prominent private practitioners and other citizens; representatives of Rotary, Lions Clubs, and other NGOs; and consumer activists/forum etc.).

Options for the structure of district agency

Several options may be available for creating the district body:

- the Zilla Parishad may itself take up the role of overall coordinating body even while the vertical management structures continue for the various schemes and programmes;
- a committee can be set up by an executive order to take up the role of coordinating body;
- a statutory body could be created by an Act of the legislature with a mandate to manage all health and family welfare schemes in the district, including measures for involvement of NGOs and private sector;
- a corporation or a company may be set up; or,
- a District Health & FW Society could be created by merging all existing health and family welfare societies and providing it with sufficient functional and financial autonomy.

Merger of all existing societies would appear to be the optimal solution simply because every district already has at least two or three societies (District Leprosy Society, District Blindness Control Society, District Malaria Society, District TB Society, Zilla Swasthya Samiti etc.) which have mainly functioned as a mechanism for flow of funds. Their merger will, therefore, help in focussing on the 'people' rather than the requirement of the programmes (e.g. that there must be a district society for it to receive the funds). Another distinct advantage of a Society is that it can raise resources and own assets.

Details of two examples (Zilla Swasthya Samiti in Orissa and district H&FW Society, Kangra, HP) are presented in Appendices to this chapter to assist States/districts think through their preferences. These are essentially a merger of all existing societies with:

- representation from non-officials,
- provision for separate accounts for the schemes where this is a requirement,
- powers to design local resource generation instruments.

Features of Orissa and Kangra (HP) models are also summarised below to provide a an overview of their structure and role.

Zilla Swasthya Samitis in Orissa

In Orissa, various societies have been merged into the Zilla Swasthya Samiti (ZSS) to form a single Society under the Chairmanship of Collector.

The ZSS is mandated, among others, to

(a) assist the Health Department in the implementation of various health and family welfare programmes;

(b) organise and involve the voluntary organisations of the district interested in health;

(c) improve existing infrastructure of the health department, including maintenance;

(d) provide training to medical and para-medical staff as well as voluntary workers; and,
(e) strengthen the management information system by standardising returns and reports and computerisation.

The ZSS consists of three bodies :
(1) a General Body of patrons, life members, annual members, ex-officio members, nominated/co-opted members and special invitees of the chairman,
(2) an Executive Body with the Collector as chairman, Zilla Parishad Chairman as Co-chairman and Chief District Medical Officer as Vice Chairman-cum-Member-Secretary, and
(3) an advisory body consisting of State level officials.

The day-to-day activities of the ZSS are supervised by the Executive Body.

The ZSS funds include
(a) membership fees,
(b) contributions and donations by individuals and institutions,
(c) Govt. aid and Grants-in-Aid,
(d) funds mobilised through the Samiti's publications and programmes, and
(e) funds collected as user charges.

The details of the structure and organisation of the ZSS in Orissa is given in Appendix-1 to this chapter. It is reported that merger has resulted in better implementation and co-ordination and smoother management of the programmes at the district level.

District Health & Family Welfare Society, Kangra

District Kangra (Himachal Pradesh) is the first participating district in the SIP to have formed an apex body for coordinating all health and family welfare programmes and activities in the district.

The 'District Health & Family Welfare Society' in Kangra consists of two bodies :
(a) a Governing Council with the Deputy Commissioner of the district as the Chairman and Chief Medical Officer of the district as the Secretary, and
(b) an Executive Body with the CMO as the Chairman.

The composition and Bye-laws of the Society are reproduced in Appendix-2 to this Chapter.

The Society or Agency (or any other alternative mechanism proposed) must be empowered to discharge management functions rather than being a mere funds-flow mechanism, so it must have sufficient degree of functional and financial autonomy. The ZSS in Orissa and the Society created in Kangra are only examples to help you construct your own model.

****

Appendix-1 to Chapter-4

Structure and Organisation of Zilla Swasthya Samitis in Orissa

I. Aims & Objectives:

I. To create awareness among the people about their rights and their responsibilities towards the health services.

II. To assist the Health Dept. in implementation of various health programmes, national, state, as well as donor funded, with special emphasis on priority sectors like population control, child survival and safe motherhood, immunization, control of T.B. & leprosy, prevention of blindness, control of malaria, health sector reform and health systems development.

III. To organise and involve in various programmes, the voluntary organisations of the district interested in health care, and to utilise their services in the implementation of health progrmmes of the district.

IV. To work in coordination with different departments of the Govt. for successful implementation of the health programmes.

V. To improve the existing infrastructure of the health department by way of construction of buildings both institutional and residential, provision of equipment and medicines, maintenance of all physical infrastructure.

VI. To provide training to medical and paramedical staff of the district and to disseminate information.

VII. To provide training to voluntary workers, samiti workers and general public.

VIII To strengthen the management information systems in the district by standardising the returns and reports and computerisation.

II MEMBERSHIP:

Any citizen of the country who has an interest in health activities and an aptitude towards social work can on request and by application become a member of the Samiti, irrespective of cast, creed and sex. There shall be following varieties of the members:

a) **Patron member :** Persons who pay Rs. 1,000/- only at one time, with an application can become a Patron Member subject to approval of the executive body.

b) **Life Member :** Those who pay Rs. 500/- only at one time with application for membership can be a Life Member subject to approvalof te executive body.

c) **Annual Members :** Those who pay Rs.250/- on or before 31st March of the year with application for membership can be an Annual Member for next financial year subject to approval of the Executive body.

d) **Ex-Officio Members :** The following officers of the Govt. and others will be ex-officio members of the Samiti by designation : Collector & District Magistate; Chief District Medical Officer; Executive Engineer (R&B)/P.W.D./R.W.S.S./G.E.D.; A.G.M. (Gridco); GM (IDCO); Project Director, DRDA; DSWO; DIPRO; ADMO (PH)/ DLO / DMO; ADMO (Med)/ DTO; ADMO (FW) / DIO; DPM (Ophth.); Zonal Joint Directors of Health Services; ZMO; Sub-collectors; SDMOs; MEIOs; District Coordinator, NGOs; Secretary, IMA; Principal, FW Trg. School; and two representatives from local NGOs.

e) **Nominated/ Co-opted members:** The Chairman can co-opt/ nominate any official or non-official to the general body and the executive body as and when necesssary.

III GENERAL BODY :-

The General body will be constituted by all the members described above. In addition, the Chairman can invite Zilla Parishad Chairman/ Local MPs and MLAs as special invitees to the general body meeting. The General Body meeting will meet at leaset twice in a year.

IV EXECUTIVE BODY:-

Executive Body will be constituted by Ex-Officio office bearers, nominated members from 2 NGOs, co-opted members and elected members from the general body.

i.	Collector & District magistrate	Chairman
ii.	Co-Chairman	Chairman, Zilla Parishad
iii.	CDMO	Vice Chairman-cum-Member Secretary
iv	State Programme officers like TB, leprosy, Ophth., AIDS, Malaria, Planning, Medical,FW etc	Members
v.	ADMO (PH)/DLO/DMO/DTO/ADMO(Med) ADMO (FW)/DIO	Jt. Secretaries.
vi.	Zonal Joint Directors	Members
vii.	ZMO	Member
viii.	Project director, DRDA	Member
ix.	DSWO	Member
x.	Executive Engineer (R&B)/PWD/	Member
xi.	AGM(GRIDCO)	Member
xii.	GM (IDCO)	Member
xiii.	2 Representatives from 2 NGOs	Nominated members
xiv.	Project Coordinator, UK Aid Project	Member
xv.	Project Coordinator, World Bank Project	Member
xvi.	Representatives of Donor agencies working in the District.	Member

FUNCTIONS OF THE EXECUTIVE BODY

- To execute the programmes and policies of the Samiti.
- To approve the annual budget.
- To regulate the expenditure of the Samiti and to rectify all expenditures.
- To review the implementation of the different programmes and
- To appoint Auditors for auditing the accounts of the Samiti.

V OFFICE BEARERS OF ZSS:-

1.	Ex-officio Chairman	Collector
2.	Ex-officio Vice-Chairman-cum-Member Secretary	CDMO
3.	Ex-officio Joint Secretaries	ADMO (PH)/DLO/DMO/ DTO/ADMO(Med)/ADMO(FW)/DIO

FUNCTIONS OF OFFICE BEARERS

(a) **Chairman/ Co-Chairman:** They will jointly or severally, preside over all the meetings of the Samiti. The Chairman shall have full financial powers and can delegate all or any powers to Vice-Chairman as and when required. He can nominate any official or non-official having interest and aptitude for social work to the General Body or to the Executive Body. He can take any disiplinary action against any office bearers as and when required.

(b) **Vice-Chairman-cum-Member secretary :** He shall nominate Jt. Secretaries to the Executive Body from amongst the members of the General Body after taking approval of the Chairman. He can delegate financial powers to the respective Jt. Secretaries. He shall call meetings of the Executive Committee at least once in a quarter and appraise the Chairman about the progress of the work. He will execute and monitor all the health

programmes. He will be the custodian of all records of the Samiti. He will be the officer responsible to sue or to be sued by the Samiti. The account of the Samiti will be operated by him. He will prepare the annual budget for placement and approval in the Executive Body meeting in consultation with Joint Secretaries.

(c) **Joint Secretaries :**They shall work as per the direction and guidance of the Vice-Chairman-cum-Member Secretary of the Samiti. They will prepare budget for their respective programmes and submit it before the vice-chairman for approval and placement in the Executive Body meeting. They shall monitor the implementation and expenditure on their programme. They shall jointly with the Member Secretary operate the account for their programme.

(d) **Members:** All the members of the Executive Body shall be expected to attend all the meetings of the Executive Body. If a member is absent in 3 consecutive meetings, his/her membership shall be deemed to have been automatically cancelled. Members are free to give their opinion in the meeting. The tenure of the nominated and co-opted members shall be one complete year from the date of nomination.

VI QUORUM :-

At least two third of the members which include office bearers shall be necessary to form the quorum for the executive body meeting.

VII FUNDS OF THE SAMITI :-

The Sources of the funds of the Samiti will be

1) Membership fees
2) Contribution and donations by individuals and institutions
3) Govt. aid and grant in aids
4) Funds mobilised by the Samiti by its publications and other programmes
5) Funds collected as users' charges

The Samiti shall have exclusive right over the property acquired by it through purchase or gift. The funds of the Samiti shall be deposited in the Savings account of any nationalised bank in the designation of the Member Secretary. The account shall be operated jointly by the Member Secretary and the Joint Secretary concerned in respect of each programme.

VIII FINANCIAL RULES

The annual budget for the respective programmes will be prepared by the respective Joint Secretaries in consultation with the Vice-Chairman-cum-Member Secretary of the Samiti strictly observing the operational guidelines issued by the agencies providing funds for the purpose. The Vice-Chairman can delegate the drawing and disbursing powers to his Joint Secretaries for respective programmes. Different cash books will be maintained for the funds received for different programmes. After approval of the budget in the executive committee meeting, all the expenditure will be made strictly in accordance with approvals. Further approval from the State Programme Officer will not be required. Any expenditure which is a deviation from the official guidelines of the programme can be incurred with prior permission of State Programme Officer, and after approval in the Executive Committee Meeting. All the cheques of any amount will be signed jointly by the Member Secretary and the respective Joint Secretary.

IX AUDIT

The Executive Body shall appoint an auditor from the Govt. or a qualified Chartered Accountant to audit the funds of the Samiti at the closure of each financial year. The Secretary who is the custodian of all records and accounts shall produce all documents for the audit and assist in the smooth auditing of the accounts. Audited account of the Samiti should be sent to the different funding agencies well in time. This will also ensure early release of subsequent instalments.

X AMENDMENT OF THE RULES AND REGULATIONS OF THE SAMITI

Whenever it shall appear to the Samii that it is desirable to amend the rules and regulations of the Samiti or to amalgamate the Samiti either totally or partially with any other society, a special general body meeting shall be convened to consider the issue. A notice shall be issued to all members of the Samiti to attend such special meeting of the general body. The proposal for amendment for rules and regulations or amalgamation of the Samiti shall be agreed to by the votes of atleast two third members of the Samiti present in the meeting. A copy of such proposal when accepted by the General Body shall forthwith be forwarded to the Additional Registrar of the Societies within one month of its acceptance.

XI DISSOLUTION OF THE SAMITI

If two third of total members of the Samiti decide for dissolution of the Samiti, it shall be dissolved forthwith.

All assets of the Samiti upon its dissolution shall become the property of the Health Department of Govt. of Orissa after clearance of all debts and liabilities of the Samiti. No property of the Samiti shall be distributed amongst its members.

XII ADVISORY BODY OF ZSS

The following personnel will be in the Advisory Board of the ZSS:

1. Secretary, Health &FW, GOO
2. Director of Health Services, Orissa.
3. Director of Family Welfare, Orissa
4. Director, SIHFW, Orissa
5. Director, MET, Orissa
6. Drugs Controller, Orissa
7. Project Director, World Bank Health Project
8. Project Coordinator, UK aid Project
9. Joint Directors of respective programmes.

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Appenidx-2 to Chapter-4

District Health and Family Welfare Society, Kangra (HP)

Objectives of the H & FW Society: Health & Family Welfare Society will work for the effective coordination and speedy implementation of GOI Health and Family Welfare Programmes including Sector Investment Programme. The Society will function as coordinating body in the District of Kangra for all Health and Family Welfare related activities including the private health sector.

The Bodies of H & FW Society: The society will have two main bodies. They are THE GOVERNING COUNCIL and EXECUTIVE BODY.

I. THE GOVERNING COUNCIL: - This will be supreme body for guiding, planning, coordination and implementation of District Health & FW Programmes and related activities.

All Policies decisions will be taken by or with the consent of governing Council. Its constituents will be as follow.

1.	Deputy Commissioner Kangra	Chairman
2.	Chief Medical Officer Kangra	Secretary
3.	Additional Deputy Commissioner Kangra	Member
4.	District Project Officer DRDA Kangra	Member
5.	District Education Officer Prim. & Sec.	Member
6.	District Programme Officer ICDS	Member
7.	Executive Engineers HPPWD (B&R) Kangra	Member
8.	District Programme Officers Kangra (DHO, DFPO, DTO, DLO, AIDS Nodal Officer and Distt. Eye Surgeon)	Members
9.	Principal HFTC Kangra	Member
10.	NGO Representative DPES, Chinmaya Tapovan Trust, ERA	Members
11.	Chairman Zilla Parishad	Member
12.	Representative, European Commission	Member
13.	Deputy Director RCH	Member
14.	Officer Incharge looking after Projects in the Health Directorate	Member
15.	District Ayurvedic Officer	Member

The Governing Council will meet at least once in six months.

II. THE EXECUTIVE BODY:- This body of H & FW Society Kangra will be responsible for day to day Implementation, Monitoring and Evaluation of the H & FW Sector Programme. It will be take decisions from time to time for speedy and effective implementation of District Plan of Action to achieve the objectives. Executive Body will have full financial powers in this regard. It will have the following constituents:-

1.	CMO Kangra	Chairman
2.	All District Programme Officer in Health Deptt. (DHO, DTO, DAPO, DFPO, DLO, & DPO-NPCB)	Members
3.	All BMOs, District Kangra	Members
4.	MEIO, District Kangra	Member
5.	Principal Health & FW Training Centre Kangra	Secretary

Rules and Regulations of District Health & FW Society Kangra:-

i. Short title:- These rules will be called "Rules of District H & FW Society Kangra."
ii. Scope :- These rules will be applicable to all the units of H & FW Department in District Kangra and will cover all the activities and personnel of H & FW Society Kangra. These rules will come into force from the day the Society is registered under Societies Registration Act of 1860.
iii. Definitions:- For these rules, the definitions will have the following meanings.

a) Act - Act shall mean – Societies Registration Act 1860.
b) Government of India - will mean Ministry of Health & FW New Delhi.
c) "The State health & FW Sector Reform Advisory Committee" - shall mean the committee constituted by the HP Government.
d) "The Governing Council" - shall mean Governing Council constituted under these rules for guiding, coordinating & planning of various activities in District Kangra for implementation of EC Sector Investment Programme.
e) "The Executive Committee" - will mean the Executive Committee constituted under these rules for day to day implementation & monitoring of H & FW Programme including RCH in District Kangra.
f) Non Government Organisations, "NGOs" under these rules - will mean Non-Governmental, Voluntary Organisations working in the health sector in execution of different activities pertaining to H & FW including RCH.
g) "Community Based Organisations" (CBOs) under these rules - will mean Non-Government Organisations working and representing community other than the NGOs, like Mahila Mandals etc. who can be involved in implementation or monitoring of health related activities.
h) "SCOVA" SCOVA under these rules - will mean State Council for Voluntary Organisations at the state level as constituted by the State Government.
i) State Government under these rules - will mean Government of Himachal Pradesh.
j) PRIs under these rules will mean Panchayati Raj Institutions like Gram Pancharyats etc.

Functions of Health & FW Society District Kangra:-

1. To undertake all activities pertaining to Health Sector reforms as envisaged in District Plan of Action in District Kangra.
2. To undertake operational and applied research activities related to H & FW including RCH.
3. To create, recruit and manage, technical, administrative, managerial, academic, consultancy and other posts in the society and to make payments for those according to rules & regulations of the society.
4. To make rules & regulations for managing the affairs of the society and to make additions, deletions and amendments in them from time to time as needed in the interest of society and programme.
5. To accept grant in aid, donations or funds in any form for the society.
6. To incur expenditure for managing the affairs of the society.
7. To purchase, hire, take on lease, exchange or otherwise acquire property, movable or immovable including funds, construct & maintaining building / buildings in the manner deemed fit as may be necessary for carrying out the objectives of the society.
8. To prepare district Plan of Action and other project reports for different activities, implement them and monitor in a time bound manner.
9. To lay down appropriate financial norms for different activities and their auditing from time to time. The Executive body shall nominate a Chartered

Accountant to audit the accounts of the society every year. The annual audit report will be placed every year in the meeting of the Governing Council.

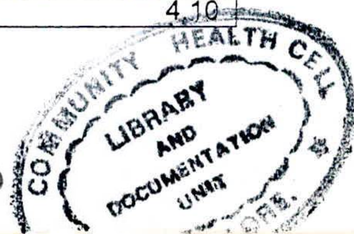
10. To enter into agreement or contract as may be deemed necessary and sequential upon or incidental to carrying out the aims and objectives of the H & FW Society.
11. To coordinate with and monitor the functioning of other District level societies in Health Department and outside.
12. To coordinate / associate with and monitor the activities of NGOs/CBOs and PRIs in the manner deemed necessary for achieving the objectives of the European Commission assisted Sectoral Investment Programme.
13. To accept contributions both in cash and kind from any NGOs/agencies in the field of Health & FW in the state or outside the state.
14. To appoint short time consultant / consultants as may be required to carry out activities to achieve aims and objectives of the society.
15. H & FW Training Centre Kangra will act as nodal centre for implementation and monitoring of the activities of European Commission Sector Investment Programme.
16. To decide and levy user-fee for various Health & Family Welfare related services and utilise the same for improvement of Health services in the District.
17. To plan and manage Social Marketing Programmes.
18. To enter into joint ventures with other institutions / organisations in the Health & Family Welfare Sector.
19. Regional Health & Family Welfare Training Centre Kangra as Nodal Institution for implementation and monitoring of the activities of this Health Sector Investment Programme Project.

Properties and Assets:- The income and property of H & FW Society Kangra, derived in any manner however, shall be applied towards promotion of objectives thereof as laid down in this memorandum of association, subject nevertheless, in respect of the expenditure of grants made by the Government of HP, Government of India or donor agencies to such limitations as these Governments / agencies may from time to time impose. No portion of income and property of the society shall be paid or transferred directly or indirectly by way of dividend bonus or otherwise, however, to persons who at any time have been members of the society or at any one of them or to any person claiming through them provided that nothing therein contained shall prevent the payment in good faith of remuneration of any service rendered to the society or travelling allowance, halting or other similar charges.

Quorum : -The quorum for the meeting of Governing Council and Executive body will be half of the total members.

Government Powers:-State Government and Central Government may jointly or individually may appoint one or more persons to review the work and progress of H & FW Society and may hold inquiries into the affairs thereof and to report thereon, in such manner as the Government may stipulate and upon receipt of report may jointly take such actions and directions as they may consider necessary in respect of any of them as dealt with in the report. The society shall be bound to comply with such directions. In addition, the Central or State Government may at any time issue directions on matters of policy to the society and society will be bound to promptly comply with such directions. Where there are different views between the State Government and the Central Government, the views of Central Government shall prevail.

Financial Management:- The H & FW Society shall maintain the account in a Public Sector or Cooperative Bank at Dharamsala / Kangra. The account shall be jointly operated by Chairman and Secretary of the Executive Committee. Proper cash book and records of all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accounts shall be maintained by the Society for which some part time help may be engaged. The accounts shall be got audited annually from the authorised agency like Chartered Accountant or others as per requirement of Government/Donor agency.

<u>Dissolution:-</u> If on winding up of the society due to any circumstances, there shall remain, after dealing with all its debts and liabilities, any assets or properties whatsoever it may be, shall not be paid to or distributed among the members of the society or any relations of them but shall be dealt with in such manner as the State Government may determine.

The Governing Council of the society with majority of two third of its members can pass a resolution for dissolution of the society.

<u>Amendment of By Laws:-</u> The By Laws can be amended any time by the Governing Council.

<u>Legal Matters:-</u> In case of legal proceedings by or against the Society, the Secretary of the Society shall be authorised to file and sign affidavits, replies etc., on behalf of the Society, to appear in various courts and authorities. Any legal help, if so required, can be engaged for this purpose and expenditure for that can be incurred out of the funds of the Society. However, all pleadings, statements/replies shall have prior or ex-post facto approval of the Executive Committee.

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Chapter-5 : Guidelines for preparing the District Action Plan (DAP)

A: Background

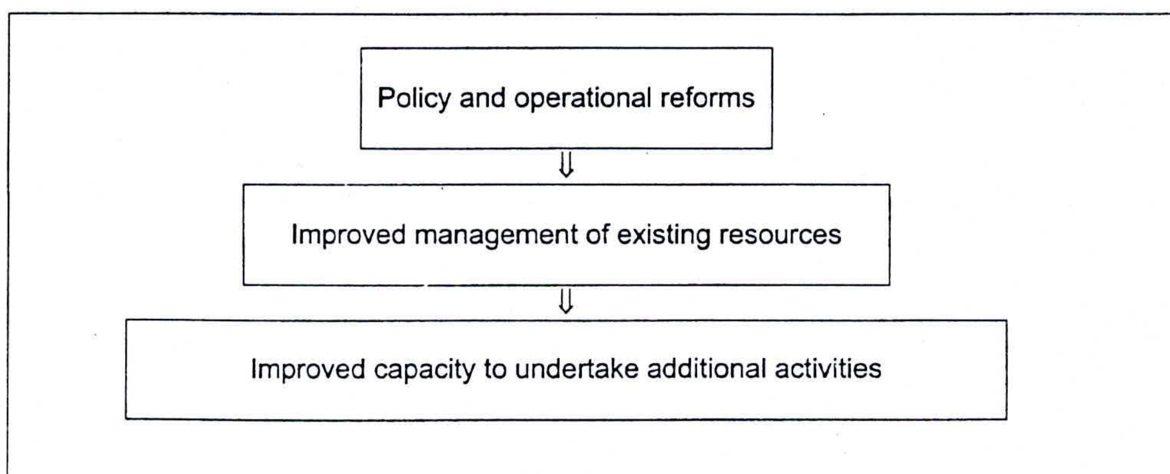
The GoI policy statement, *The Paradigm Shift*[1], calls for

- Decentralisation (delegating responsibilities) and devolution (delegating authority);
- Community needs based planning;
- Sustainability of infrastructure and workforce;
- More efficient financial management, specially ways of linking funding to performance;
- Improved quality of clinical services.

How can the above aspirations be turned into reality ? Can this be possible under guidelines and directions from above which may fail to take note of the local realities ?

There is overwhelming evidence that the absorptive capacity of the system has been incapacitated due to decades long practice of designing top-down schemes on the one hand and a near complete absence of freedom of action (e.g. alternative deployment of existing resources that may be somewhat different from the laid down 'norms') on the other.

The SIP has been designed on the premise that there is an urgent need to introduce *operational* or *micro policy* changes that will turn the aspirations of *The Paradigm Shift* into reality. Many changes are needed to develop holistic improvements to the ways services are planned and managed at the district level. There is an urgent need to concentrate on improving *management* of existing resources and activities rather than extending the coverage of services, or extending infrastructure which may add to existing problems. Money and effort devoted to improved management will have a considerable impact on the effectiveness of existing services. It will also increase the sector's capacity to absorb resources effectively, and will lead to the extension of services and improvement of quality. This can be depicted as in the diagram below:



[1] See Chapter-1 : Sector Investment Programme: An Introduction

B: What is the focus of DAP ?

The focus of the district action plan (DAP) will be on reform. That is, the DAPs will focus on identification of factors that inhibit 'functionality' of the Family Welfare Programme. This is why the terms of reference for group work at district workshop focussed at identification of problems hindering implementation of existing programmes and possible solutions to overcome the same.

The problems hindering the Programme may be structural, systemic or operational. Structural problems may emanate from division of labour or administrative structures. For example, civil hospitals in a district may be under a separate line of command than the Sub-centres, PHCs and CHCs and this separation may be a cause of poor referral practices because functional linkages are not clearly laid down. A problem can be termed as systemic if it is caused by rules, norms and procedures. For example, maintenance is poor even though funds were there but they were placed at the disposal of the PWD whose priorities were new constructions rather than repairs. The operational problems refer to staffing and resource gaps.

Very often, an identified problem can not be clearly placed under one category or the other because they are inter-linked. For example, it may be possible to minimise lack of staff or resource gap through managerial action locally, but the existing procedures do not allow freedom of deployment to the district programme managers.

The DAP will be nothing but a series of reform oriented initiatives addressing structural, systemic and operational problems. The DAP can, thus, be described as articulated responses to the following inter-related questions:

- Certain structural / systemic / operational problems were identified during the district planning workshop and subsequent consultation process at lower levels.
- Which of these problems do you propose to address in year-1?
- What is the support needed for implementing the changes / solutions?
  [For some of the operational problems, you might want to pilot (test on a small scale) the solutions proposed which will cost money. You may also want some of the managers to be trained in managing facilities, funds and changes proposed, which will also cost money. On the other hand, for the structural and/or systemic problems, you may need intervention from the State level - e.g. issuing a Government Order (GO) allowing deployment of staff, levying user charges and so on, which do not involve any costs to you.]
- On what basis you want your progress (in overcoming the problems) to be measured?

Each of the changes proposed will constitute a component of the DAP. Some components may take very little time for implementation while others (e.g. piloting a new approach to service delivery) may take longer (more than a year).

C: Planning horizon

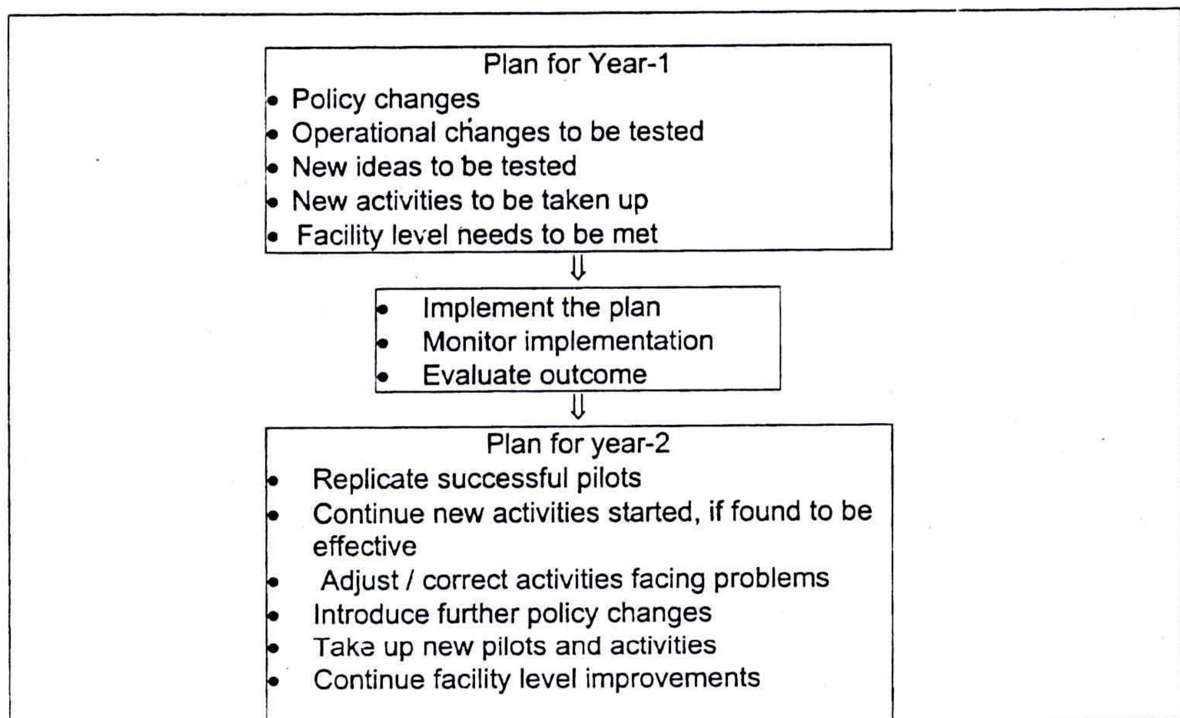
Overcoming policy and operational problems is a complex task. It may not be feasible to address the entire range of problems simultaneously. The SIP, therefore, does not envisage the District (or State Plans) to be a comprehensive 5-year document. Rather, it envisages that the districts will evolve:

- a vision statement as to what the district wants to achieve in the next five years, or, in other words, where it wants to go from where it is now;
- a prioritisation of the current problems and gaps;
- an action plan for addressing the systemic and operational problems which should be tackled in the first year ; and,
- proposals for taking up new activities which the local programme managers feel must be taken up but can not be taken up because no funds are available.

Towards the end of the first year, a review of progress will be made which will set the agenda for the next year. Thus, the plans for year-1 will roll over into the second year's plan for

(a) replicating ideas which proved to be worthwhile,
(b) correcting ideas which did not yield desired results,
(c) continuing new activities, if they prove to be yielding reasonable improvements, and
(d) continuing with the experiments (which needed more than one year time span to show results) started in the previous year.

This rolling nature of the planning process could be depicted as shown in the diagram below.



D: Essential Contents of the DAP document

District Profile: Present the demographic and health related information for the district as a whole as well as for each of its development Blocks. Provide information on mortality and morbidity pattern in the district, including seasonal variation. List out the primary causes of infant mortality, low birth weight, malnutrition, RTIs, low contraceptive prevalence, high birth rate, high maternal mortality and disability.

State clearly if the above details are not available for the district. Creating this information base can, in fact, become a component of the DAP.

Situation analysis: Provide a summary of (a) the availability of all health facilities in the district – public sector as well as the NGO and private sectors (use a map indicating road and railway infrastructure in the district as also the population of all the towns where hospitals and nursing homes etc. are located), (b) present status of availability of referral services provided by the public sector health facilities, (c) the problems caused by the existing norms, rules and procedures.

Components for first year's plan: State which of the problems identified during the consultation process you want to address in the first year. The write-up should explain the logic for selection and sequencing.

For each component, prepare a three-part 'Component Management Protocol' to provide a summary of what the component seeks to achieve, what will be the time needed to implement the component , what is the cost involved and what will be the criteria for assessment of progress and release of funds. The three parts are:

- Part-I: 'Component description'. This should summarise the problem identified, solutions proposed, the support (funds or State/Central level approval to policy changes) needed to implement the solution, the time frame and the costs involved[2]. [The components may be serially numbered to facilitate reference.]

[2] Some operational problems can be solved without any external support but may require funds which are not available. Adopting modified OPD timings at a health facility to suit the 'clients' can be done without any external intervention or financial assistance. Launching a continuing skill development training for the paramedical workers at larger hospitals (where there is enough case load) through a system of roster can also be done without any external interventions but the funds may not be available.

For some other problems, State Govt. intervention / approval may be called for. Allowing the district Society/Agency to introduce measures for enhancing financial and functional autonomy of the programme managers at lower levels and to introduce user charges for some of the services may require the approval of the State Govt.

For still others, piloting may be called for to test the feasibility of solutions before higher level intervention can be sought, e.g. alternative arrangements for locating medical and paramedical workers and adoption of an alternative referral system.

- Part-II: 'Time Schedule'. This is to be prepared as a Gantt chart for all the activities to be undertaken under the component.

- Part-III: 'Cost estimates'.

E: Assigning values to benchmarks

After the component details have been prepared, a set of benchmarks are to be derived from these. Then, appropriate values are to be attached to them in such a way that their achievement will provide enough funds to ensure that there are no funds shortages at any time during implementation phase (see chapter-8 for more details).

Following operational steps are suggested for this exercise:

- list the benchmarks in the following format, leaving the values column blank:

List of benchmarks						
Sl. No.	Benchmark description	Related Component		Expected month of achieving	Value attached Rs. Lakh	Indicator of achievement
		Com. No.	Com. Description			

- Next, summarise the expenditure estimated to occur in each quarter of the year 2000-01 for all components included in your plan for year 2000-01. Use the following format:

Funds needed for implementing components					
Component No.	Component description	Funds needed in year 2000-01			
		April-June	July-Sept	Oct-Dec.	Jan-March
Total requirement for all components					

- Now, determine the values to be assigned to the benchmarks in such a way that the total expected receipts for each quarter cover the total expected expenditure. However, do not try to draw funds far in excess of the need. The money sitting idle in one place may deprive another of funds.

F: Illustrative examples:

The formats to be used can best be described with practical examples. These are presented in the Appendix to this chapter to explain how the components may be formulated. Based on discussions in the district level workshops held in the past few months, these are only illustrative and in no way should be treated as 'the recommended solutions'.

Only Part-I (component description) has been presented for all example components while Parts II and III have been presented only for the first example component. This is because preparation of time and cost estimates is rather straight forward. [Do note that you have to add the details for the cost calculations, as illustrated for Example Component-1 in the Appendix.]

G: Approval process and role of State Sector Reform Cell (SRC)

The Programme Management Bureau (PMB) in Department of Family Welfare has decided that the resources needed for the DAPs will flow through the State Sector Reform Fund (SRF) and the task of releasing funds to the districts will be handled at the State level. Except for a start-up amount, the State will have to 'earn' the funds for DAPs through a set of benchmarks demonstrating the technical assistance and policy support provided to the districts in the implementation of the DAPs.

Accordingly, after the DAP proposals have been prepared and submitted to SRC, following sequence of activities will take place:

- SRC will examine the DAP proposals and may ask the district Core Team to incorporate changes, if any.
- After the SRC has approved the DAP proposals, the same will be forwarded to the PMB. At this stage, the SRC will propose the amount that should be released by PMB on approval of the DAP.

> The 'approval of DAP by PMB' will be an automatic benchmark and will 'trigger' release of a part of year-1 outlay for the DAP to the SRF. The SRC will determine the amount to be released on approval on the basis of funds required for implementing the DAP activities until the funds linked to the early benchmarks derived from DAP components become available.

- After the DAP has been approved by PMB, the State will prepare and submit its plan for supporting the DAP, as a separate component of State EC Programme Implementation Plan (SECPIP), to the PMB. This will contain a set of benchmarks against which the PMB will release the funds (for DAP) to the State.

> Except for the trigger amount linked to approval of DAP, the district will receive the funds only against the achievement of benchmarks indicated in the DAP.

Management of DAP will become a component in the SECPIP to ensure that the State provides the necessary support that the districts will need for the smooth implementation of their plans. It is essential, therefore, that the DAP proposals are finalised in consultation with the SRC so that the time schedule for components involving technical assistance and policy support as reflected in the DAP proposals is consistent with the time schedule that the SRC will indicate in this regard.

> After a plan has been approved by SRC, the PMB would presume that any deviations from existing State policies would have been agreed to. Similarly, approval of a plan by PMB will imply approval of any deviations (included in the proposals) by the Department of Family Welfare, Govt. of India.

H: Evaluation Criteria

The SRC / PMB will examine if provisions already exist for one or more of the components of a plan and may send it back for clarification. It must be ensured, therefore, that a component is not merely a duplication of effort.

After the preliminary screening as above, SRC / PMB will evaluate the components of a plan on following criteria:

- Necessity : problems identified for resolution should be clearly stated, bringing out why a proposed component should be taken up ahead of other interventions which do not find a place.
- Cost effectiveness : is the proposed component the optimum solution among all possible solutions?
- Improvement : will the implementation of the proposed component improve the health situation in the district ?
- Replicability : does the proposed component hold the potential for being replicated elsewhere in the district / State / country ?
- Sustainability : is the component sustainable after the SIP funding ceases ?

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Appendix to Chapter-5
Examples of DAP components

Sector Investment Programme **Component Management Protocol** **Part-I: Component Description** **Implementing Agency** : District ABC			
Component Number	1	Component Title	Decentralisation of functions and devolution of powers
Problems identified		▪ Programme managers at district and sub-district levels are unable to deploy medical and para-medical staff as they have no control over subordinate staff. ▪ Inability to use available resources fully because the programme managers do not have any flexibility. ▪ Maintenance of buildings is poor because (a) funds provided are not sufficient and (b) allocations for maintenance are placed at the disposal of PWD whose priorities may are different.	
Solutions proposed		▪ Allow deployment of para-medical staff within PHC areas by the Medical Officer; and transfer of para-medical staff and deployment of medical officers within the district by the Chief Medical Officer. ▪ Allow non-plan, non-salary State grants to be used in a flexible manner, subject to overall limits and allow shifting from one sub-head to another (within same head) for all Centrally Sponsored Schemes. ▪ Transfer funds and responsibility of maintenance to the district level coordinating body which will distribute the resources taking into account resources generated through user charges vis-à-vis funds needed for maintenance.	
Support needed for implementing changes		▪ State government to issue a G.O. on the first and third and the Central Government on the second. ▪ Training of medical officers in personnel and financial management.	
Cost of implementing changes		Rs. 6.50 lakh (as per details given in Part-III)	
Time needed to implement changes		▪ Total planned time : 6 months ▪ Expected month of start: May, 2000 ▪ Expected month of completion: October, 2000 [Identified training institutions will continue to provide on-the-job problem solving advice. This will be an integral part of the MOU with the institution(s).]	
Sustainability of the changes		Not applicable for this component. The fees payable to the training institutions will include the cost of on-the-job problem solving support for one year.	
Benchmark(s) derived from this component		GO for decentralisation of functions and devolution of powers issued. Value: Rs. 20.00 lakh.	

EC-GoI Sector Investment Programme
Component Management Protocol
Part-II: Time Schedule for the Year 2000-01

Implementing Agency: District ABC

Example Component Number	1	Component Title	Decentralisation of functions and devolution of powers

Sl. No.	Activity description	Months (April, 2000 to March 2001)											
		A	M	J	J	A	S	O	N	D	J	F	M
A: deployment of staff													
A-1	submit proposal to SRC		—										
A-2	discuss and negotiate with SRC			—									
A-3	State Govt. order is issued				—								
B: delegation of financial powers													
B-1	submit proposal to SRC		—										
B-2	discuss and negotiate with SRC			—									
B-3	State Govt. order is issued				—								
C: introduction of user charges													
C-1	develop proposal		—										
C-2	submit proposal to SRC			—									
C-3	discuss and negotiate with SRC				—								
C-4	obtain State orders empowering district Agency /Society					—							
C-5	issue orders for introduction of user charges and retention/utilisation of collections						—						
D: Flexibility to use non-salary funds/allocations available for Centrally Sponsored Schemes [To be taken up by SRC]													
Training of medical officers in personnel and financial management													
5	Identify training institution(s) [about 150 officers are to be trained]		—										
6	Prepare the course content		—										
8	Prepare training schedule		—										
9	Conduct the training			—	—	—	—	—					

Note: The identified training institution(s) will continue to provide on-the-job problem solving support to the officers trained. A Memorandum of Understanding will be executed with the identified training institution(s) to this effect.

EC-Goi Sector Investment Programme
Component Management Protocol
Part-III: Cost Summary

Implementing Agency: District ABC

Example Component Number	1	Component Title	Decentralisation of functions and devolution of powers

Expenditure category	Expenditure (Rupees in lakh) estimated to occur in						
	Financial year 2000-01					After 2000-01	Total
	April-June	July-Sept.	Oct.-Dec.	Jan-March	Total		
A: Non-recurrent Costs							
Civil works including renovation	------------------- Not applicable for this component -------------------------------------						
Vehicles	------------------- Not applicable for this component -------------------------------------						
Medical Equipment	------------------- Not applicable for this component -------------------------------------						
Non-medical equipment including	------------------- Not applicable for this component -------------------------------------						
Training and workshops	0.30	0.90	0.30	--	1.50	--	1.50
Consultants' fees	2.50	2.50	--	--	5.00	--	5.00
Other non-recurrent costs	------------------- Not applicable for this component -------------------------------------						
B: Recurrent costs							
Contractual staff payments							
Health consumables							
Non-health consumables							
Vehicle maintenance including POL expenses							
Building maintenance							
Other recurrent costs							
Total for the component	2.80	3.40	0.30	--	6.50	--	6.50

[Norms for calculations are attached]

Calculation Norms for Component Number-1

Number to be trained: 150 medical officers

Assumptions and calculations:

- Training will be conducted at Institute XXX in 5 batches of 30 officers each.
- The Institute has agreed to provide training (including post training on-the-job problem solving support) @ Rs. 1.00 lakh per batch of 30 officers. In addition to course material, the Institute will provide boarding and lodging within the agreed cost. The duration of the course will be one week. Due to other commitments, the Institute has agreed to schedule one batch per month.
- Payment to the Institute will be made in two installments of Rs. 2.50 lakh each: first installment is to be paid immediately before the start (i.e. in May, 2000) and the other after completion of three batches, i.e. in September, 2000.
- The TA/DA allowances will be paid separately. These are estimated to cost Rs. 1000/- per officer on an average. Total TA/DA cost will therefore be Rs. 1.50 lakh. In first quarter (April-June, 2000), the expenditure on this account will be Rs. 30,000; that in the second quarter Rs. 90,000 and the remaining Rs. 30,000 in the third quarter.
- Payment to the Institute has been included under "consultants' fees" category. The TA/DA to be paid to the medical officers has been placed under training costs.

Sector Investment Programme
Component Management Protocol

Part-I: Component Description

Implementing Agency : District ABC

Component Number	2	Component Title	Rationalising ANMs' work routine and streamlining their MIS
Problems identified	• The ANMs complain that they are over-burdened and most of their time is taken away by preparation of returns prescribed for various schemes and programmes. • On the other hand, however, data is not available on a sizeable number of RCH indicators.		
Solution proposed	▪ Undertake a work & motion study of ANMs and Male workers with a view to rationalise their roles and responsibilities with reference to the existing programmes. ▪ Streamline the management information system with a view to eliminate un-necessary documentation load and to devise a system for eliciting information from a relatively small number of basic records.		
Support needed for implementing change	▪ Sector Reform Cell to identify and engage a suitable agency for the field work and subsequent data analysis. ▪ MIS streamlining will be carried out through a team of programme managers with the help of the agency engaged for work and motion study.		
Cost of implementing changes	▪ Rs. 7.00 lakh (does not include the payments to be made to the agency)		
Time needed to implement changes	▪ Total planned time: 4 months ▪ Expected month of start : May, 2000 (assumes that SRC will be able to identify the agency in April, 2000) ▪ Expected month of completion: August, 2000		
Sustainability of the changes	Not applicable for this component		
Benchmark(S) derived from this component	▪ Launch of revised work schedule and revised MIS set up. Value: Rs. 15.00 lakh.		

Sector Investment Programme
Component Management Protocol

Part-I: Component Description

Implementing Agency : District ABC

Component Number	3	Component Title	Improving community's access to the health worker.

Problem	The access to the health worker is limited, since the worker visits a village only twice a month and is not available at her/his Sub-centre more than twice a week. As a result, any citizen coming to the Sub-centre, whether for cure or prevention, usually finds the facility locked.
Solution proposed	Ask the Panchayat to identify and place a para-medical worker at the Sub-centre on a full time basis. Such a para-medical worker should know basics of preventive health as well as basic cures for common diseases along with a medicine shop catering to the entire catchment area of the Sub-centre. The Panchayat may finance this worker or, alternatively, allow the person to charge for the services. The above model will be piloted in a few Panchayats having Sub-centres with ANM quarters and, if found useful, will be extended to all such village Panchayats.
Support needed for implementing change	A one-time grant to the Panchayat (@ Rs. 1.00 lakh per Panchayat) for upgrading the facilities at the selected Sub-centres (e.g. to add another room to house the medicine shop or to construct a delivery room or to improve the existing building and facilities).
Cost of implementing changes	Rs. 17.00 lakh [Rs. 15 lakh for 15 Panchayats and Rs. 2.00 lakh for meetings, travel and other related expenses, including a sample household survey by PSM Department of Medical College XXX.]
Time needed to implement changes	▪ Total expected time : 10 months : 1 month for identification of Panchayats, 3 months for preparatory activities (dialogue with the community, identification of para-medics and their training, upgradation of facilities) and 6 months for recording observations. ▪ Expected month of start: May, 2000 ▪ Expected month of completion: February, 2001
Sustainability of the changes	Not applicable as this is a pilot.
Benchmark(S) derived from this component	▪ Placement of paramedics at the identified Sub-centres. Value: Rs. 10.00 lakh.

Sector Investment Programme
Component Management Protocol

Part-I: Component Description

Implementing Agency : District ABC

Component Number	4	Component Title	Improving referral set-up
Problem		The referral services in the district are very poor due to lack of blood banking facilities, specialists, lab facilities and other infrastructure.	
Solution proposed		At present, blood banking facilities are available only at 5 hospitals, other than the district hospital. In the first instance, therefore, these hospitals will be strengthened to provide the full range of emergency services, on a 24-hour basis. The available strength of specialists and general duty medical officers will be re-located from CHCs to these places where providing accommodation is not a problem. These hospitals will also be used as the sites for providing skill development training for the ANMs. In addition, three private sector hospitals located at towns X, Y and Z, will also be recognised as a referral centre. In return for the recognition, the hospitals have agreed to provide free ante-natal care to below poverty line (BPL) clients and to promote ORS and breast feeding. They are also prepared to train Govt. ANMs in handling normal deliveries and minor obstetric complications. A memorandum of understanding will be signed with them in this regard under which they will also display the charges for the various package of RCH services.	
Support needed for implementing change		State Govt. concurrence will be needed for redeployment and re-location of medical and paramedical staff from other facilities as may be recommended by the district Society / Agency. State Govt. orders will also be needed to delegate powers to contract the private practitioners.	
Cost of implementing changes		None [costs relating to facility improvement are included in the relevant components (*)]	
Time needed to implement changes		• Total planned time: 6 months [includes time needed for drawing up the re-worked implementation for referral services and obtaining the approval of district Society/Agency and/or Sector Reform Cell, execution of MOU with the private sector hospitals and effecting staff re-deployment/re-location. Time required for facility level improvements etc. are reflected in the relevant components] • Expected month of start : June, 2000 • Expected month of completion: November, 2000	
Sustainability of the changes		Not applicable	
Benchmark(s) derived from this component		Re-worked referral plan approved by State Govt. Value Rs. 40.00 lakh.	

(*): Requirements will vary from facility to facility. Therefore, while deployment needs etc. must be assessed in an integrated manner, fresh investments should be assessed separately for each facility. This will later help in monitoring improvements made by each of the facilities.

Sector Investment Programme
Component Management Protocol

Part-I: Component Description

Implementing Agency : District ABC

Component Number: 5	Component Title: Improvement of services at Civil Hospital XYZ
Problem	Hospital located at XYZ has access to blood bank and is capable of providing the full range of RCH referral services on a 24-hour basis. However, the existing services are of poor quality due to (a) vacancies of specialists, (b) lack of facilities (running water, waiting hall / room for patients/escorts, toilets) and (c) lack of funds for day-to-day operations.
Solution proposed	▪ Improve facilities. ▪ Meet specialists' shortage by withdrawing them from the hospitals where no blood banking facilities are available or where their skills can not be optimally utilised. ▪ Introduce user charges which may be retained at the facility for maintenance. ▪ Constitute a governing / management body with the medical-officer in-charge as the member-secretary and local community leaders-not necessarily limited to PRI representatives – as the members and allow them to fix the user charges and generate additional resources for further improvement of the facilities.
Support needed for implementing change	▪ Funds for one-time investment for improvement of facilities. ▪ Approval of the proposal (for setting up the governing / management body by district Society / Agency and/or Sector Reform Cell. [Proposal for re-location of staff is included in component-4]
Cost of implementing changes	▪ Rs. 20.00 lakh as one-time investment.
Time needed to implement changes	▪ Total planned time : 12 months [including time needed for new construction] ▪ Expected month of start: June, 2000 ▪ Expected month of completion: May, 2001
Sustainability of the changes	Services and facilities created will be sustained by using the collections made through introduction of user fees.
Benchmark(s) derived from this component	▪ Identified shortcomings rectified and hospital made fully functional.. Value: Rs. 30.00 lakh.

Sector Investment Programme
Component Management Protocol

Part-I: Component Description

Implementing Agency : District ABC

Component Number: 6	Component Title: Improvement of services at Civil Hospital DEF
Problem	Hospital located at DEF does not have access to blood banking facility at present but is otherwise well placed to provide all other RCH services. Utilisation has also been good. However, there has been a fall in the quality of services (reflected in a fall in the utilisation rates) due to (a) lack of facilities (running water, waiting hall / room for patients/escorts, toilets) and (b) lack of funds for day-to-day operations.
Solution proposed	▪ Improve facilities. ▪ Generate resources through user charges to ensure maintenance of services. ▪ Constitute a governing / management body with the medical-officer in-charge as the member-secretary and local community leaders-not necessarily limited to PRI representatives - as the members and allow them to fix the user charges and generate additional resources for further improvement of the facilities.
Support needed for implementing change	▪ Funds for one-time investment for improvement of facilities. ▪ Approval of the proposal (for setting up the governing / management body which would be competent to decide the user charges) by district level coordinating body (which may only prescribe an upper limit for the user charges for different types of services).
Cost of implementing changes	▪ Rs. 12.00 lakh as one-time investment.
Time needed to implement changes	▪ Total planned time: 9 months ▪ Expected month of start : June, 2000 ▪ Expected time of completion: February, 2001
Sustainability of the changes	Services and facilities will be sustained by using collections made through introduction of user charges
Benchmark(s) derived from this component	▪ Management Board set up and user charges introduced. Value: Rs. 25.00 lakh.

Sector Investment Programme
Component Management Protocol

Part-I: Component Description

Implementing Agency : District ABC

Component Number	7	Component Title	Improved utilisation of manpower
Problem		The doctors' positions remain perpetually vacant at a large number of rural PHCs. In many of the rest, doctors are day-time visitors as the support services/facilities (e.g. schools for children) are not available at their places of posting.	
Solution proposed		Concentrate the doctors at the facilities/ locations where the support services are available. Adjust the timings for the outlying PHCs (from where the doctors have been re-located) so that the facilities (where the doctors have been re-located) can provide 24-hour delivery services and (if the facility has easy access to blood bank) the full range of referral services. The outlying PHCs will revert to being dispensaries with pre-declared timings. The doctors have agreed to use their personal vehicles for attending the PHCs if they are paid a monthly transport allowance, calculated on the basis of distance involved. The above concept will be piloted in one or two sub-divisions before considering replication / extension.	
Support needed for implementing change		Approval of the State Government to the proposal.	
Cost of implementing changes		Rs. 2.00 lakh. (one year's cost of monthly transport allowance for the re-located doctors)	
Time needed to implement changes		• Total planned time: 4 months • Expected month of start: August, 2000 • Expected month of completion: November, 2000	
Sustainability of the changes		Not applicable as this is a pilot	
Benchmark(s) derived from this component		None.	

Sector Investment Programme
Component Management Protocol

Part-I: Component Description

Implementing Agency : District ABC

Component Number	8	Component Title	Improved utilisation of sub-centres.
Problem		In a significant number of cases, the ANMs are not staying at the place of their posting because the Sub-centres are located well outside the village and the ANMs have a sense of insecurity. In many such places, there have been cases of theft and break-in.	
Solution proposed		Adopt and announce a policy for locating a Sub-centre which takes due note of the personal safety of the ANM on the one hand and the responsibility to the community on the other. Identify the location of all existing Sub-centres with a view to identify the most vulnerable. Negotiate with the Panchayat concerned to make arrangements to re-locate the sub-centre at a secure place within the village. Offer the Panchayat a one-time grant (say, Rs. 1.00 lakh) in return for providing an alternative accommodation for the Sub-centre. The grant may be used to part-finance the rent for the alternative accommodation for the Sub-centre. The Panchayat may also be allowed to decide alternative use of the existing Sub-centre building. If the Panchayat does not agree to the suggestion, the Sub-centre may be shifted to another Panchayat village which is willing to offer appropriate accommodation. This proposal will initially be piloted in respect of 10 most vulnerably located Sub-centres.	
Support needed for implementing change		Approval of the Sector Reform Cell to the proposal.	
Cost of implementing changes		Rs. 10.00 lakh (for providing the one-time grant to the Panchayats).	
Time needed to implement changes		• Total planned time : 4 months • Expected month of start: September, 2000 • Expected month of completion: December, 2000	
Sustainability of the changes		Not applicable	
Benchmark(s) derived from this component		Sub-centre started functioning from the new location. Value: Rs. 5.00 lakh.	

Sector Investment Programme
Component Management Protocol

Part-I: Component Description

Implementing Agency : District ABC

Component Number: 9	Component Title: Improving community awareness and involvement
Problem	Community involvement is the weakest link in the system.
Solution proposed	Launch a campaign in every Panchayat to involve the members of existing committee's (e.g. Mahila Swasthya Samiti, Mahila Mandal, Water users' Committee etc.) in the Panchayat village. Train/reorient them in basics of preventive care at the Sub-centre serving their village. To instill a sense of importance, special letters will be written to each one of them by the district programme manager. A system will be put in place to collate the responses which will be placed before the executive body of the district Society / Agency, detailing action taken on the suggestions received from the members. A newsletter will be launched for distribution among the members focussing at selected RCH topics and for disseminating their experiences, ideas, suggestions and complaints. Special recognition / appreciation letters will be written by the Chairperson of the Society / Agency to the individuals whose contribution has been outstanding. The district Society / Agency will set up a Community Response Cell at the district headquarters with the involvement of leading NGOs to look after the above activities. The district media officer and his/her staff will act as the secretariat for the Cell. To begin with, this component will be taken up in all villages of the district. Later, it may be extended to cover the urban areas also.
Support needed for implementing change	The training / orientation material will be developed in-house, with the help and involvement of leading NGOs active in the district.
Cost of implementing changes	Rs. 20.00 lakh (for preparing training / orientation material, organisation of training/ orientation camps and for preparation and dissemination of monthly newsletter.)
Time needed to implement changes	• Total planned time: 6 months • Expected month of start: July, 2000 • Expected month of completion: December, 2000
Sustainability of the changes	The cost of continuing this activity is estimated to cost less than Rs. 1.00 lakh per annum (most of it on the newsletter). The Society / Agency will allocate sufficient funds to continue this activity.
Benchmark(s) derived from this component	Survey among recipients of letter and newsletter completed to assess the effectiveness of this intervention. Value: Rs. 10.00 lakh.

Chapter- 6: Flow of funds, reporting and accounting systems

A: Approval process for the plans and initial release of funds

A-1: State EC Programme Implementation Plan (SECPIP)

The State EC Programme Implementation Plan (SECPIP) will be submitted to the Programme Management Bureau (PMB) in the Department of Family Welfare, Govt. of India. The Sector Reform Cell (SRC) of the State, while submitting its proposals, will determine and communicate to the PMB, the amount of funds needed on approval of the SECPIP. This 'trigger' amount will be the first benchmark for every SECPIP and will be determined on the basis of funds required for implementing the SECPIP activities until the funds linked to the first benchmark derived from the SECPIP components become available (see Section-H, Chapter-3: Guidelines for preparing SECPIP).

If no changes are needed, the PMB will convey its approval and release the 'trigger' amount. Otherwise (i.e. if any modifications are needed) the PMB will notify the SRC suitably and the latter will submit a revised plan after (a) revising the relevant component management protocols taking into account the comments / suggestions of the PMB, and (b) modifying the list of benchmarks (if necessary).

A-2: District Action Plan

After the DAP proposals have been prepared, they will be submitted to the SRC. The SRC will examine the DAP proposals and may ask the district Core Team to incorporate changes, if any.

After the SRC has approved the DAP proposals, the same will be forwarded to the PMB. At this stage, the SRC will propose the amount that should be released by PMB on approval of the DAP. Approval of DAP by PMB will also be an automatic benchmark and will 'trigger' release of a part of year-1 outlay for the DAP. The SRC will determine the amount to be released on approval on the basis of funds required for implementing the DAP activities until the funds linked to the early benchmarks derived from DAP components become available.

The PMB will examine the DAP proposals and, if necessary, may suggest modifications to the SRC. The SRC, in this case, will carry out the necessary amendments with the heip of district Core Team and send the revised proposals (along with the revised list of benchmarks, if necessary) to the PMB.

As soon as the DAP has been approved by PMB, the State will prepare and submit its plan for supporting the DAP, as a separate component of SECPIP, to the PMB. This will

contain a set of benchmarks against which the PMB will release the funds (for DAP) to the State (see Section-G, Chapter-5: Guidelines for preparing DAP).

B: Flow of funds to the States

Funds will be channelled through State Finance Department where the States have a demonstrated efficient past financial record. Otherwise, they will be released to a designated State Society (like the SCOVA).

All States which receive SIP funds through the normal Government budgetary mechanism will create a State Sector Reform Fund (SRF), designated as such in an appropriate budget line, with effect from the GoI financial year 2000 – 2001. All SIP funds received by the State Government will be credited to this State SRF. The State SRF will be kept free of debilitating financial controls (e.g. periodic freezes on drawals).

In respect of States which receive SIP funds through the SCOVAs or similar agencies, separate accounts will be maintained for the SIP funds. To maintain a separate accounting identity for the funds provided out of EC assistance, the SCOVA or other agency may open a separate bank account titled ' State Sector Reform Fund'. If it has a common bank account, the title ' Sector Reform Fund' may be given to ledger heading in which the SIP funds are accounted for.

Every participating State will also furnish an Assurance of having instituted adequate budgetary safeguards to ensure that SIP funds do not lapse at the end of a financial year or end of a Plan period and are also protected from calls other than activities included in the approved plans. The Assurance will include creation of a State SRF free of debilitating controls, as described above.

The benchmarks against which funds will flow to the States from DoFW will be of two types, namely,

- those related to activities associated with State-wide activities, pilots, policy reviews etc.
- those related to management of and support to the DAPs.
  (see Section-H, Chapter-3: Guidelines for preparing SECPIP)

C: Flow of funds to the Districts

After a DAP has been approved by the PMB, funds linked to DAP approval (the trigger benchmark) will be placed in the State SRF. The trigger amount will be passed on to the SIP district to start the DAP activities.

Additional funds for DAP will be released upon achievement of benchmarks identified by the State relating to its role in the management of and support to the DAP and will be

credited to SRF. Additional funds to the district will be released from the State SRF upon the achievement of benchmarks derived from the DAP.

When a DAP benchmark is achieved in time or where the delay is nominal, the SRC will satisfy itself with the evidence presented as the means of verification of the benchmark and release an amount equivalent to the value attached to the benchmark(s) in the approved plan.

In case of serious delays, the SRC will seek PMB's advice, forwarding its comments on the reasons cited for the delay. [See chapter-8: The benchmark funding system, to know more about what could happen when the benchmarks are not achieved as planned.]

D: Quarterly Progress Report (QPR)

After implementation has started, every implementing agency will submit a quarterly progress report (at the end of every June, September, December and March) to the agency providing funds to it. That is, from the State to PMB in respect of the SECPIP and from the district to the SRC in respect of DAP.

The format for submitting the QPR is given at Appendix-I to this chapter.

E: Plan for the next year

The planning cycle will be the Government financial year, namely, 1st April to 31st March. The first plan may, however, be for a part of the year if the plan is starting later in the year.

Towards the end of first year of implementation, an Annual Plan proposal will be submitted for the next year. Plan for the next year should reach the PMB end of January of the coming financial year (i.e. plans for year 2001-02 should reach the PMB by January, 2001). The plan should consist of

(a) a component-by-component review of the first year's plan,
(b) monthly time schedule for the components to be continued in year-2,
(b) component management protocol for new component(s), and,
(c) list of benchmarks for year-2.

For every implementing agency, components will be serially numbered throughout. For example, if a year-1 SECPIP had 10 components, and 4 of these are continued in year-2, their numbers will not change. Therefore, for new components to be taken up in year-2, the numbers will start at 11.

F: Release of funds against benchmarks

After one or more benchmarks in the approved plan (DAP or SECPIP) have been achieved, an authorised officer of the implementing agency will submit a request letter to its funding agency (PMB in respect of SECPIP and SRC in respect of DAP). The format for requesting release of funds upon achievement of a benchmark is given at Appendix-II to this chapter.

In the case of a SECPIP, the PMB will authorise release of the amount equal to value attached to the benchmark, after examining the evidence/documentation in support of the achievement of the benchmark.

In the case of a DAP, this function (as mentioned above) has been assigned to SRC, and the release will be made from the funds available in the State SRF.

Implementing agencies have the freedom to combine request for more than one benchmarks. The format makes a provision for this possibility.

G: Accounts to be maintained and Audit

Every implementing agency will maintain full account of expenditure incurred against each item of expenditure included under the approved plan.

The audit arrangements for the RCH Project will be made use of under this programme as well.

Start up funds were provided against qualifying benchmarks (Rs. 20.00 lakhs to a State for setting up Sector Reform Cell and Rs. 15.00 lakhs to each district for setting up the District Agency / Society). These funds were provided to meet the expenses relating to preparation of State / district plans and for operationalising SRC / District Agency. It is necessary, therefore, that full accounts are maintained for the utilisation of the start-up funds provided.

Balances may be used as buffer and carried over for implementation of activities in the approved plan.

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Appendix-I to chapter-6

Format for Quarterly Progress Report

Sector Investment Programme

Quarterly Progress Report

Quarter ending ....

Implementing Agency:

Component ID number	Budgeted Expenditure		Actual Expenditure		Status of Component (tick one box)		
	During the quarter	Cumulative (Upto the quarter)	During the quarter	Cumulative (Upto the quarter)			
					On target ❑	Complete ❑	Delay ❑
					On target ❑	Complete ❑	Delay ❑
					On target ❑	Complete ❑	Delay ❑
					On target ❑	Complete ❑	Delay ❑
					On target ❑	Complete ❑	Delay ❑
					On target ❑	Complete ❑	Delay ❑
					On target ❑	Complete ❑	Delay ❑

Notes on delayed Components

Component ID number	Reason for delay	Intended corrective action

Note: Use additional sheets if space is insufficient.

Appendix-II to chapter-6
Format for request for release of funds upon achievement of a benchmark

Sector Investment Programme

Implementing Agency...

To, ...
....
....
....

Sir/Madam,
This is to inform you that this implementing agency has achieved the following benchmark(s) in respect of the plan for the year .... :

Bench-mark serial number(*)	Benchmark title	Value attached (Rs. Lakhs)	Means of verification

(*) as appearing in the approved plan

Evidence/documentation in support of the achievement of the above benchmark, as stipulated in the approved plan, is enclosed.

Kindly arrange to release the amount equal to the value attached to the above mentioned benchmark.

Yours sincerely,

(authorised signatory)

Notes:

- States / districts should send a copy of the requests (along with evidence/documentation in support of the achievement of the benchmark) to EC Family Welfare Programme Office, New Delhi.

Chapter-7: Carrying out the Policy Reviews

The *RCH Programme* promises the community that a well-defined set of services will be available to them in an assured manner. It also emphasises the quality of these services, and their user-friendliness. The *Community Needs Assessment Approach* requires a consultative and participatory planning approach for the RCH services, as well as for all other services rendered by the primary healthcare system, including the CHCs.

Commitments of this order call for serious consideration of the capacity of the system to deliver, and require changes to that end. The following questions are examples of the issues that need to be addressed:

- Are the present population based infrastructure norms for health infrastructure appropriate to meet the demands of the RCH Programme?
- Should decisions about infrastructure also take account of private and NGO facilities available?
- How to identify and grade private and NGO facilities?
- If first referral services are not available for want of specialists, what changes to personnel policies are needed to attract and retain specialists?
- Should the list of FRUs be changed, to take into account present and future availability of specialists?
- Are job definitions up to date?
- What administrative and financial powers are to be delegated to various levels?
- Identification of positions that must have female service providers preferably, and building this requirement into the transfer / posting rosters.
- How to encourage greater and better performance by linking funds to performance?
- Can some of the national programmes or parts of them be stopped in areas where the disease burden or the presence of alternative service facilities does not warrant these services?
- How can the Government facilities become more sustainable, in terms of material, human and financial resources?

Such questions and their answers lie primarily within the jurisdiction of the State Governments. A policy debate between the States, the Centre and other stakeholders, based on a competent analysis done by the States, should therefore be an ongoing process. This has not taken place, though the experience of the RCH and other national programmes points to the need for such review of policy, followed by appropriate restructuring, wherever needed.

The Sector Investment Programme (SIP) offers the opportunity for these *Policy Reviews* and supports changes in policy, improvement in systems, procedures and norms. Though the SIP will provide the financial resources and technical expertise for the Policy Reviews, the Reviews are *not* confined to the SIP or to the activities supported by the

SIP. The Reviews would be *sector-wide*, i.e. covering the entire Health and Family Welfare sector.

Definition of the Sector: In the GoI-EC Financing Agreement (1997), the sector is defined as the 'National Family Welfare Programme of the GoI'. This includes improvement and integration of women and children's health included in *primary health care*, as well as public *health activities* upto *the emergency or first referral obstetric care* level. Also included is referral care for sick children aged 0-5 years. The existing linkages and the impact of the outcome of these reviews on curative medicine and public health should not, however, be ignored. The review is expected to cover not only the public sector (i.e. Government), but also the private and NGO sectors.

According to the SIP Document agreed between the EC and the GoI, States implementing the World Bank supported State Health Systems (SHS) Projects have the option of not carrying out the Policy Reviews, if similar exercises have taken place under the SHS. So far, however, all such State Governments with which the ECTA team has interacted, have decided to carry out these Policy Reviews.

The Policy Reviews have been grouped under four multi-dimensional headings, namely:

1. Workforce Management Options;
2. Delineation / Decentralisation;
3. Rational Use of Infrastructure; and
4. Performance Based Funding Options.

Four Task Forces were set up in the Department of Family Welfare for discussing and finalising the Terms of Reference (ToRs) for each of the policy areas. A set of model terms of reference were finalised by the Task Forces, and have been provided to the States selected for intensive work in the first year of SIP. The States may add to or modify these, in order to accommodate any State specific or other aspect that may be considered relevant. While some States have suggested minor changes, the ToRs have been mostly accepted as relevant in States where the workshops have been held so far.

ECTA facilitators, Programme Managers and others using this Handbook are strongly urged to read and familiarise themselves with the *Model Terms of Reference for Policy Reviews* finalised by the GoI Task Forces. For convenience, a summary of the Model ToRs is given in the Appendix to this chapter. The summary contained in the Appendix is by no means complete or comprehensive. The complete *Model ToRs for Policy Review* is available separately, and is recommended for thorough study.

Apart from policy changes as such, the Policy Reviews are also expected to provide leads and inputs for the SECPIP from year 2 onwards. Pending the completion of the

Policy Reviews, State Governments have been requested to formulate a SECPIP for year 1, which can merge into the plans for year 2 onwards.

GoI wants the Policy Reviews to be done by State Governments themselves. The temptation to contract out the Review to an institution and then to sit back should be resisted. The State Governments may, of course, use institutions or research agencies to carry out specific parts of the Reviews, particularly those requiring extensive fieldwork, information gathering, resource mapping, computerisation of data etc.

Wherever institutions / agencies are used, the State Government's guidelines and procedures for procurement of services will apply. Engagement of institutions/ agencies should preferably be done through a competitive bidding process. Institutions/ agencies should be informed of expected outcomes, processes, methodologies, sample sizes etc. in the form of clearly and unambiguously written Terms of Reference (ToRs). All bidding (technical and financial) should take place on the basis of these ToRs.

The Policy Reviews are intended to collate, analyse and present viable policy options, rather than to collect information. Fresh baseline surveys, KAP surveys etc. are therefore not to be encouraged. These tend to consume a disproportionate amount of time and money.

A large amount of State and district specific information is available in existing literature, which must be accessed and used. Some examples of such literature are:

- Census Reports.
- National Family Health Surveys (NFHS) I and II.
- Surveys done by the National Sample Survey Organisation.
- Rapid Household Surveys and Facility Surveys under the RCH, commissioned by GoI.
- Documentation (Appraisal Reports, Review Mission Reports, Baseline Reports, Project-end Evaluation Reports) of present or past donor assisted projects.
- Performance Reports submitted by the State or district.
- Plans prepared under the CNAA, or under other national programmes.
- Record of the consultative planning process adopted under the SIP.
- Reports of Government Committees, Administrative Reforms Commissions etc.
- Press Reports and complaints / suggestions from the public and public representatives.
- Litigation under the Consumer Protection Act and public interest litigation relevant to the State.

Debates about Government policy often tend to remain confined to Government offices. A deliberate attempt must therefore be made to carry the debate into the community. This effort could take several forms, some of which could be:

- Associating consumer rights activists or organisations with the SRC or Task Forces overseeing the Policy Review;

- Associating elected public representatives with the SRC or Task Forces;
- Interviews or Focus Group Discussions with past, present or potential users of public healthcare systems;
- Discussions with private and NGO healthcare providers, aimed at developing partnerships;
- Inviting public opinion through advertisement (if nothing else, this strengthens commitment to reform, and shows the level of public interest in the issue);
- Opening up the entire process of policy debate to the Press to and other media.

It is crucial that all actual and potential stakeholders in the sector reform process are enabled and encouraged to contribute. The community has the right to information, as much as it has the right to services. The Policy Reviews should, therefore, be open and transparent.

The Policy Reviews will need competent persons with vision to carry them out. The task can possibly be entrusted to the H&FW Sector Reform Cell. Alternatively, task Forces can be constituted to oversee the Policy Reviews. In case the task is given to more than one group of persons, they must meet often enough to ensure an integrated approach.

The Policy Reviews would definitely need a capacity within the State Government, to handle at least the following tasks:

- Literature review;
- Identification of collaborating institutions / agencies;
- Development of ToRs for any institutions / agencies that would be used;
- Guiding the institutions / agencies;
- Compilation / collation of information acquired from diverse sources, including the institutions / agencies;
- Preparation of background papers, discussion papers, situational analyses, policy drafts etc;
- Incorporating various inputs into a draft report, and its eventual development into the final report of the Policy Review.
- Subsequent actions like preparing papers for policy decisions on the recommendations of the Policy Reviews;
- Incorporating the results of the Policy Reviews into the SECPIP for year 2 onwards.

The functions of the Sector Reform Cell (see chapter-2: Role of SRC) take note of these requirements. The Cell is expected to have:

- An empowered body to take decisions on policy reforms;
- Technical expertise to study, analyse and present the reforms needed;
- A secretariat to handle the documentation.

Whatever be the mechanism and process adopted for the Policy Reviews, a clear *Workplan* for handling the Policy Reviews must be the first step to be taken by the Cell or Task Force given the job of carrying out the Policy Reviews. The Workplan must include the methodology, scope, responsibility, time and cost estimates for the task. Indicative time estimates are given in chapter 7 of the Model ToRs for Policy Reviews.

The Model ToRs for Policy Reviews mention (in chapter 8 of the Model ToRs) a meeting of State Government representatives and institutions selected by them. This is to be organised by Department of Family Welfare (DoFW). Work pertaining to the Policy Reviews should not be held up for this meeting.

GoI may undertake preparation of a national level summary of States' Policy Reviews or commission a set of national policy reviews. These are decisions yet to be taken by DoFW.

The cost of the Policy Reviews, including institutional costs and consultancy fees, constitutes a part of the SIP. Funds released against benchmarks achieved are the source of funds for the SIP. Benchmarks consisting of processes or outcomes related to the Policy Reviews are recommended for use in the first year of the SIP.

Inclusion of the Policy Reviews as a key activity in the SIP offers a unique opportunity. It may be regarded as the beginning of an iterative policy debate. It is expected that the policy reviews would lead to the many micro policy and operational reforms needed to make the system deliver on the promises implicit in the macro policy reforms like the CNAA and the RCH Programme.

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Appendix to Chapter-7

Summary of ToRs for Policy Reviews

A: Work Force Management Options

The shift from target driven family planning and other vertical family welfare programmes to a holistic, integrated and demand driven RCH Programme requires a substantial reorientation of the existing health and family welfare workforce and a new way of involving the private medical sector and indigenous systems of medicine in a more integral, meaningful and sustainable manner.

While several initiatives have been taken to develop the capabilities and capacities of the workforce in the health and family welfare sector in the country, there have been critical shortcomings. Some of them have had to do with the sporadic nature of various vertical interventions, which led to a mismatch between skills and required job functions. Others were related to lack of relationship between demand and availability of health services at designated or suitable health facilities. Besides, there are wide gaps between notional and real availability of health services. Fragmentation, overlap, poor integration of knowledge and skills has plagued training interventions, which have otherwise been of sizeable proportions. These and several other factors have resulted in lack of job satisfaction and motivation amongst the workforce.

The objective of this Policy Review will, therefore, be to develop and articulate a *State Policy on Workforce Management* in the health & family welfare sector, which can effectively attract, recruit, post, develop and retain competent and trained health care personnel at their designated places of work. The review would present the policy framework with particular focus, inter-alia, on the following:

- Projected demand and supply of each staff category for the next five years and action to be taken to redress the imbalances;
- Relevance of the policy of deploying two multipurpose workers, one female and one male, at the peripheral level, in view of the experiences with differences in staff supply rates and resultant workloads;
- An assessment of existing job descriptions vis-à-vis the technical capability required for delivery of RCH services at sub-centre, PHC and referral facilities and recommendations for more meaningful job descriptions for each functionary category;
- An assessment of the design and content of basic training for the ANM and LHV vis-à-vis the technical capability required of them for delivery of RCH services, with recommendations for strengthening the basic training;
- A review of in-service training set up in the State and its effectiveness with recommendations for an appropriate system;

- An assessment of the feasibility of introducing skills audit system as part of the in-service training systems proposed for districts to measure the impact of in-service training interventions with recommendations on its structure and necessary protocols;
- A review of the training capacity of the training institutions in the State with plans to strengthen it;
- A review of the remuneration packages of the trainers and stipends/allowances with recommendations for rationalisation, including performance based payment;
- A review of existing policy/measures for career development of trainers and recommendations on improvements needed.
- Suggest ways of imparting a client friendly face to the public sector services.

Workforce policy review will also examine the feasibility of introducing a new level of medical competence for handling all but surgical interventions related to the RCH.

It will also review the existing incentives for encouraging public sector specialists and other functionaries to work in the rural areas and their effectiveness.

B: Delineation of Roles and Responsibilities

The RCH envisages that services are planned on the basis of Community Needs Assessment Approach (CNAA). However, if the existing administrative structures and practices continue and tight budget lines are retained, the district administration may not be able to respond well to the changes necessary in implementation. Thus, the success of the CNAA based planning of services will depend on how well and fast the existing administrative structures and practices are modified to provide the district administration the autonomy that is implied in the approach. A more advanced form of decentralisation would mean conferring greater autonomy not only on districts, but on blocks and village administration, and extending further to the individual service institutions.

The objective of Review for Delineation of Roles and Responsibilities, therefore, will be to prepare a framework and plan of action for decentralisation at district and below district levels. This would , inter-alia, include the following:

- identification of the appropriate level (State, district, below district and facility) for each major area of responsibility - technical, managerial and financial;
- criteria for measuring the preparedness at each level in taking over the functions hitherto discharged at higher levels;
- technical assistance required for facilitating the preparedness for decentralisation;
- a time schedule for the transfer of functions to the appropriate levels; and
- the indicators that can be used for measuring the process of decentralisation.

The Review would also suggest (a) a framework for enhancing the financial and functional autonomy of the local bodies in the State in relation to the National Family Welfare Programme in general and the RCH Programme in particular; (b) a framework

a buffer.

- *What happens if a benchmark is not fully achieved?*

There are many reasons why benchmarks might not be achieved. One is that they might be unrealistic. Another is that there may be accidents or other uncontrollable and unpredictable events.
Suppose a benchmark payment claim is submitted, but the benchmark has not been met. If the paying agency (State or PMB) believes the benchmark can be fully met with a little more time and effort, it will ask the implementing agency (district or State) to make further efforts and re-submit the claim after achievement.

Suppose a benchmark has not been met, and the paying agency believes it is either not possible or no longer desirable to try to fulfil the benchmark. In this case, the paying agency is likely to authorise payment of the full amount if

- the benchmark was nearly achieved.
- there is a good explanation of why it could not be fully achieved.

If two or more benchmarks have not been met, and the paying agency believes too little effort is being made, the implementing agency will be warned about its performance. In extreme cases, payments may be denied for one or more benchmarks, or the implementing agency removed from further participation in the Programme.

- *What happens if a benchmark is attained later than expected?*

The timing of achievement of each benchmark must be noted in the implementing agency's action plan. However, there are many reasons why delays could occur, and in consequence it can be anticipated that some of the scheduled dates of achievement will not be met.

If a benchmark is not achieved exactly on time, there will usually be no financial penalties. If, for example, the intention was to attain the benchmark in June but it is not in fact attained until August, this will mean only that the payment against the benchmark will be a little later than expected. The full payment will be made, but later than planned.

Of course, this might create difficulties of cash flow for the implementing agency. It will obviously be preferable to avoid late completion of several benchmarks, and to avoid very long delays.

If there are repeated and lengthy delays in achievement of benchmarks, this will mean that the whole programme of reform will be delayed. The PMB will warn the implementing agency if its plan is failing to meet expectations. In extreme circumstances, the PMB may decide to remove the implementing agency from further

participation in the Programme.

- *Must benchmarks be met in the planned sequence?*

This issue is best explained by example. Suppose the first scheduled benchmark is the establishment of the State Health and Family Welfare Sector Reform Cell, and the second is devolution of medical staff selection to Districts. The implementing agency experiences difficulties in establishing the Sector Reform Cell, but proceeds with – and successfully implements – the second reform. Can the implementing agency then submit a claim for payment for the second benchmark?

There is no simple answer to this question. On the one hand, if it is <u>always acceptable</u> to "skip" a benchmark, then activities might not be performed in the most efficient and effective sequence. On the other hand, if it is <u>never acceptable</u> to "skip" a benchmark, some much-needed reforms will be slowed down.

The PMB will use judgement on this matter, when reviewing benchmarks in the State's action plan. The State will similarly apply judgement when deciding whether to make payments against benchmarks in a District's action plan.

When deciding whether it is acceptable to "skip" a benchmark, the paying agency will ask these questions.

- Are the reasons for delay in achieving an early benchmark understandable? If the implementing agency has obviously tried very hard, and the delays are outside its control, then the PMB will be more inclined to make payments against later benchmarks.
- Is the implementing agency still committed to completing the early benchmark? The PMB will expect to be convinced that the early (and delayed) benchmark is likely to be attained in due course, and that the implementing agency has a plan to overcome the delay.
- Is there reason to believe that good progress is being made? The PMB is mainly interested in progress on reform. If work is proceeding efficiently and effectively, even though the early benchmark has not been met, it is likely to authorise payment against the later benchmarks.

- *Is there any point in exceeding a benchmark?*

Experience shows there is a risk that the performance goal specified as a benchmark can be seen as the maximum improvement necessary. This is usually undesirable.

Suppose, for example, that the implementing agency is committed to a benchmark promising a 10% improvement in immunisation coverage. It initiates a campaign in a few villages that proves to be very successful, and the benchmark is achieved much

sooner than was anticipated. The implementing agency then decides not to continue the activities that were causing the improvement in coverage. It decides no more efforts are necessary, because there will be no additional payment for exceeding the benchmark.

In fact, the paying agency will take note of performance exceeding the agreed benchmarks, and will balance high performance in one area against a failure to attain a benchmark in another area. It will therefore always be wise for the implementing agency to show improvements in performance – and in particular to continue those activities which are contributing to success.

A good way of continuing the successful initiatives is to develop and negotiate further benchmarks based on the same activities. For example, if the implementing agency has successfully achieved a 10% improvement in immunisation coverage, it can benchmark itself to a further 10% improvement in the next financial year. Alternatively, if measles vaccine coverage is poor compared to other antigens, a benchmark can commit the implementing agency to improvement in measles vaccine coverage.

- *Which benchmarks are best: input, process or outcome benchmarks?*

It was noted earlier that a benchmark must prove there is a worthwhile change. This means it must be both strongly related to health improvement and it should be verifiable. An input benchmark is easy to measure but does not guarantee improved health. An outcome benchmark guarantees health improvements but may be much more difficult to measure.

Planning teams must use their judgement. However, it will probably make sense to make use of input and process benchmarks initially, and then progressively change over to process and outcome benchmarks. This means there will be the time to develop better measures of the more informative process and outcome benchmarks. Here is an example of a set of benchmarks that progresses from being input-based to being process- and outcome-based over time.

Benchmark	Means of verification	Expected time of achievement
FRU fully staffed, equipped and buildings renovated. (input)	Verified by observation.	August 2000
Referral protocol established and all identified FRU services functioning fully. (process)	Verified by observation.	March 2001
65% bed occupancy rate in the FRUs made operational. (process)	Verified from hospital data.	October 2001
Reduction in MMR by 2/1000 as compared to the baseline. (outcome)	Verified from the rapid household survey.	March 2003

- *How many benchmarks should there be?*

It will probably be unwise to have only a small number of benchmarks, each with a large money value. This increases the risk of failure to obtain payments matching or exceeding expenditures. The risks are particularly high if there is only a small number of linked benchmarks – that is, where the likelihood of meeting subsequent benchmarks is dependent on meeting the first.

However, there should not be too many benchmarks. There is a cost associated with measurement and documentation.

A balance is needed. For example, it might be expected that a District Action Plan would contain 5 to 15 benchmarks per year. The number depends, however, on the type of benchmark, and the consequent degree of effort required for measurement and documentation.

- *Will benchmark funding be unfair to disadvantaged States and Districts?*

Benchmarks are intended to measure sustainable improvement. Each State and District may be starting at a different level, but the starting differences are largely neutralised by measuring the change or rate of change, rather than absolute values.

For example, the vacancies in Medical Officers' posts is a widespread problem, but its magnitude varies from district to district. A benchmark related to this issue can specify that 50% of the vacancies should be filled up within six months, and the doctors found physically in place after one year. This benchmark neutralises the difference in the actual number of vacancies of MOs. Fulfilling this benchmark would require adoption of personnel policies (such as district cadres for doctors) which enable easy recruitment and retention.

- *How far ahead should the benchmarks be set?*

There is a requirement that annual plans be prepared by each State and District, and that benchmarks are included which cover the full year. However, the implementing agency will have the opportunity to revise aspects of its plan (including the benchmarks) during the year.

There must also be an outline plan for the full SIP period, and this should be a rolling plan (updated each year so it always looks five years ahead). This will help ensure investments are appropriately staged and that there is a sense of the long-term direction of reform. However, there is also a need for flexibility: reform will not always proceed smoothly, and changes of direction may be required on the basis of experience.

In summary, the best strategy is to plan ahead as far as possible but also make sure that

the plans are regularly reviewed and revised as necessary.

- *Are benchmarks restricted to activities supported by SIP funding?*

No, they are not. Benchmarks can also be related to activities funded from the Government Budget, or by other donors. How far the activity is critical to system improvement should be the main factor in choosing the benchmark.

For example, there might be a UNICEF-supported project intended to establish child growth monitoring activities in villages. Successful completion of the project could serve as a benchmark, even though there is little or no cost to the SIP.

- *Will total payments always equal total expenditures?*

Generally, yes. However, as mentioned before, there may be unspent balances available from the start-up funds (provided against the qualifying benchmark, viz., setting up of SRC in the case of a State and the District Agency in the case of a district). These unspent balances will serve as a buffer.

In earlier phase, values to the benchmarks should be so assigned that the implementing agency has a positive balance at the end of the year. This will enable the implementing agency to continue activities which were started in the previous year, until the payments related to benchmarks for the next year's plan become available.

In the last year of the plan, however, balances available from previous year may be adjusted against the total requirement in the last year. Or, the implementing agencies may be allowed to retain the earlier balances to continue one or more of the activities beyond the last year. In any case, implementing agencies will be required to obtain the approval of the SRC / PMB in deciding the utilisation of whatever balances may remain available with them at the and of the SIP.

- *Is it best to set easily achieved benchmarks?*

There may be a temptation to set benchmarks that are easy to achieve and have a high payment, in the expectation that the implementation agency will get a lot of easy money. This should not be done, because the implementation agency probably will not be able to spend this money sensibly. Moreover, the PMB is unlikely to approve such an action plan because it fails to meet the key criterion: whether as much will be achieved in terms of the health of women and children as could reasonably be expected.

Idle or unspent money is as undesirable as shortage of money. Money sitting idle in one district has an opportunity cost. Another district may be suffering for want of the same money. The inflows against benchmarks likely to be achieved must therefore be

balanced against likely expenditure in a comparable time period.

G: A footnote: openness, collaboration and mutual learning

When benchmark funding is introduced for the first time, there is a tendency towards optimism. Funding agencies believe it will be easier to distribute funding without constant dispute, service providers think they will be obtaining additional funding with little effort (as long as the benchmarks are conservative), and both parties tend to believe a simple change in funding incentives will be sufficient to overcome the many longstanding constraints to change (like attitudes, mindless rules, lack of training, professional jealousies, self-serving behaviour, and so on).

The reality is usually quite different, and it will soon become clear that a new kind of working rules have to be learnt. One aspect is that service providers may form the view that it is in their interest to set easily achieved benchmarks and to negotiate the highest possible funding level for each. The funding agencies will tend to have the opposite view, and friction is inevitable.

Another aspect of the new system is that there is no easy and entirely objective way of deciding the value of one benchmark relative to another. One implementing agency will begin to look at how much it is being paid in comparison to another implementing agency, and start to question whether it is fair.

These kinds of problems are resolvable. However, the benchmark funding approach is not simple, and much time and effort is needed in designing the details if it is to deliver the intended benefits. All parties must be open about their attitudes, and be willing to have frank discussions about their concerns. If the process is open and collaborative, much progress will be possible in improving the health status of the people.

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Annex-I to chapter 8

Some process indicators that might be used as benchmarks

Child Health

Proportion of children immunised before their first birthday with 6 antigens
Proportion of hospitals and maternity facilities officially designated baby friendly
Proportion of diarrhoreal episodes treated with ORT
Proportion of children under 1 year receiving measles vaccine along with Vitamin A
Proportion of scheduled immunisation sessions actually held in the district compared to the scheduled sessions
Percent newborn initiated breast feeding (BF) within half an hour of birth in public facilities
Incidence of low birth weight
DPT1 – DPT3 dropout rate
Proportion of villages in outreach having regular and dependable supplies of oral rehydration salt (ORS)

Maternal Health

Maternal Mortality Rate
Average number of married women receiving attention (MWRA) per ANM
Average number of ANC visits per pregnant woman
Proportion of institutional deliveries (can be classified by female literacy status or caste / economic status)
Proportion of districts reporting maternal deaths more than 4/1000 live births
Average number of EOC facilities/20000 births
Mean age at effective marriage (for use late in the programme)
Number of maternal deaths per thousand live births
Proportion of all births in the EOC facilities
Proportion of women with complications treated in the EOCs
Obstetric case fatality rate (CFR)
Caesarean section rate
Proportion of institutional deliveries
Proportion of pregnant women receiving first ANC before 16 weeks
Proportion of women receiving any PN care visit
Median distance for an EOC facility in the district
Number of days ambulance is available compared to days off road
Proportion of vacancies/days doctor is available, compared to days scheduled
Proportion of ANMs/LHVs with appropriate personal transport
Proportion of deliveries with trained assistance
Average time lag between arrival of patient at facility and initiation of treatment
Obstetric CFR
Total number of maternal deaths
Proportion of pregnant women immunised against Tetanus

Abortion Services

Abortion rate
Abortion death as a percentage of maternal deaths
Percentage of districts with safe abortion facilities (1 facility per 20,000 births)
Age-specific abortion rate
Repeat abortion rate
Percent of service delivery points equipped for safe abortion care
Proportion of admitted obstetric complications that are abortion related
CFR for abortion complications
Proportion of clients seeking MTP services accepted contraception
Proportion of MTPs in the first trimester
Proportion of MTPs performed using vacuum suction

Family Planning

Existence of an approved State Population Policy addressing fertility and family planning
Proportion of State Budget allocated to Family Welfare
Proportion of districts reporting adequacy of staffing in programme managers
Total and Age specific Fertility Rates
Contraceptive Prevalence Rate (CPR)
Method Mix
Crude Birth Rate (CBR)
Percentage of high order births (more than 3)
Median length of open birth methods and closed birth intervals
Proportion of districts having a Logistics Management Information System (LMIS)
Total and Age Specific Fertility Rates
CPR
Method mix
Discontinuation rate for spacing contraceptives due to negative reasons
Existence of Annual Programme (including financial) Plan for the district
Unmet demand for contraception
Vacancy rate for Male Health Workers
Discontinuation Rate
Use failure rate for contraceptives

RTIs and STDs

Average number of facilities/ district having laboratory facilities for diagnosis of common RTIs/ STDs
HIV prevalence (age and sex distribution)
Use of epidemiological data (hospital based) for developing annual programmes
RTI/ STD prevalence (age and sex distribution)
Proportion of service providers trained in RTI/ STD management
VDRL positivity among pregnant women among institutional deliveries
Incidence of opthalmia neonatarum among institutional deliveries
Percent clients properly screened for RTIs before trans-cervical procedures
Percent facilities stocked with adequate condoms and STD education material
Stock-out of Doxycycline capsules
Partner management rate

Re-occurrence/ re-infection rate

Policy reforms

Days of delay in releasing funds from State to districts
Days of delay in PWD starting building construction
Days of delay in filling posts
Proportion of funds allocated by GoI and remaining unspent
Setting up of State Health and Family Welfare Sector Reform Cell
Completion of Policy Reviews
Setting up of District H & FW Authorities/Agencies
Decentralisation of key activities (eg, drug purchase, staff appointments)
Agreed pilots successfully completed
Preparation of agreed DAP with evidence of community participation
Setting up of district agency and number of meetings
Setting up of monitoring and supervisory systems
Percentage of staff attending training
Percentage of facilities (by type) staffed
Mean time drug unavailable in facilities
Reported satisfaction of beneficiaries ascertained by structured surveys
Percentage of unspent funds to allocation
Provision of audited accounts
Completion of epidemiological/demographic surveys
Percentage of facilities with water, power and working equipment
Reported satisfaction of beneficiaries
Evidence of increased utilisation of the facility
Evidence of information based planning (eg, scheduling of clinics locally)
Number of hours/days for which key equipment/vehicle is non-functioning
Number of days lost through staff absence

Annex-II to chapter-8

An illustration of first-year benchmarks for a District Action Plan

[This is only an example of the benchmarks that might be included in a District Action Plan. It is not intended that they should be copied uncritically in real life.]

The district of Charapani in Apna Pradesh is participating in the EC supported SIP. It has two distinct parts in terms of terrain. A riverine valley area with prosperous irrigated agriculture, agro-industries and trade, constitutes about 40% of the area of the district. The rest is upland, consisting of a plateau rising into the Madhya Bharat hill range. The uplands constitute 60% of the district, and of this half is forest, including reserve forest. The forest area is home to a scattered tribal population. The uplands have only rainfed or tank fed agriculture, subject to monsoon failures.

In years of severe drought, the marginal cultivators and landless labour migrate either to the more prosperous parts of the district, or to other districts. A large part of the upland area is good only for pasture, though some enterprising farmers have started tree crops or orchards on such lands, in the last 10 years.

District population (1991) is 13.75 lakh. Male literacy is 59%, about the same in all rural areas of the district, but only 34% among S.T. males. Female literacy is 43%, but there is a marked difference from the valley area to the upland area. Female literacy among S.T. women is only 18%.

There are 11 Blocks and 11 Tehsils, with coterminous boundaries. Two of the Blocks are predominantly forested and these also have the S.T. population. Of the other nine, four Blocks constitute the uplands and five fall in the valley area.

The district town, also named Charapani, is an A-grade Municipality, and had a population of 2.5 lakh in 1991. It is expected to grow to about 4 lakh by 2001, and may then be converted into a Municipal Corporation. The increase in urban population is accounted for equally by three reasons: in-migration, natural growth, and expansion of municipal boundaries.

The metre gauge railway line through Charapani town may be converted to broad gauge soon, and then it will grow even faster. There are two other large habitations with about 50,000 population each. These have C-grade municipalities. The public sector health infrastructure is as shown below.

District Hospital (150 beds)	1	Sub-centres	137
Municipal Hospital (30 beds)	1	Municipal Dispensaries	5
Taluk Hospitals	4	PP Centres (Taluk Hospitals)	2
CHCs	7	UFWC (District Hospital)	1
PHCs	28	Health Posts	14

Private sector practitioners have a strong presence at the district headquarters and are

also present in the two smaller towns. There is a rundown NGO hospital in one of the forest Blocks, but the uplands and forest Blocks are generally very short of medical facilities.

District IMR is 65, but is probably about 100 in the uplands and forest areas. MMR is unknown, but may be around 4/1000 and possibly 6/1000 in the uplands.

The district workshop for the SIP has been done, and has decided to carry out the participative planning process at Block level and separately in the three Municipalities. The work done so far indicates the following activities to be started in year 1, though civil works and equipment procurement may continue beyond year 1.

Activity	Estimated cost (Rs. Lakhs)
1. Complete the participative planning process.	6.00
2. Prepare the DAP, mainly for the rural areas.	1.50
3. Carry out health KAP study and facility survey in urban areas.	1.00
4. Prepare a sub-Plan for the urban areas.	.25
5. Study tour to Kerala and Orissa for 5 district officials, followed by a small workshop to disseminate the knowledge gained	1.50
6. Renovation of buildings and addition of equipment, blood storage, O.T. and generator for NGO hospital in forest Block (doctors/staff are available there).	39.75
7. Retraining of all ANMs with over 10 years service in a package of skills, including counselling and supervision.	5.00
8. Training Needs Assessment for M.O.s and ANMs.	0.50
9. Close down beds in the two outlying PHCs in the forest Blocks, convert them to dispensaries, and relocate staff and equipment to the Block headquarters CHCs. Doctors will operate from the CHC.	2.00
10. Manual of responsibilities and powers for all levels of H&FW personnel.	1.00
11. Increased delegation of powers (Government Order needed).	-
12. Quarters for Specialists and MOs and essential paramedical staff at 3 CHCs (2 forest area + 1 uplands).	60.00
13. Addition to CHC buildings, O.T.s, labour rooms, water supply, generators at 3 CHCs.	38.00
14. Blood storage facility at two Taluk hospitals in the smaller Municipalities.	8.50
15. Study of caseload and facilities at all Taluk hospitals and CHCs to correctly identify FRUs for the district (1 forest Block CHC + 1NGO facility to be included as FRUs anyway).	0.20
16. Full operationalisation of 3 public sector FRUs in Taluk hospitals.	27.00
17. Crash recruitment of ANMs at district level.	0.50
18. Spot recruitment of doctors.	0.30
19. Renovation of cold chain (cost borne by UNICEF – Rs. 40 lakhs).	-
20. Addition of RTI/STI clinic in district hospital, including additional posts cost for one year.	7.00
21. Monitoring and concurrent evaluation	5.00
Total	205.00

Of these listed activities, Rs.42 lakh approximately are expected to be spent in the first half year, Rs.72 lakh in the second half-year and the rest will spill over to the later part of the District Action Plan (DAP) period. Possible benchmarks could be as follows.

For first half-year

S.No	Benchmark	Value (Rs. lakh)	Means of Verification
1	D H & FW Agency constituted	15.00	Registration and bye-laws.
2	DAP approved by PMB in GoI	10.00	Approved DAP Document.
3	Plans/estimates for constructions	5.00	Approved plans/estimates.
4	Orders placed for cold chain	7.00	Confirmation by UNICEF.
5	TNA for M.O.s and ANMs done	3.00	TNA document.
6	All vacant positions advertised	5.00	G.O. and advertisement.
	Total	45.00	

For second half-year

S.No.	Benchmark	Value (Rs. lakh)	Means of Verification
7	Retraining done for 25% of the ANMs needing retraining	5.00	Trained ANMs' list, training module, random evaluation.
8	NGO Hospital upgraded and functioning as FRU	20.00	Observation, interview with hospital management, patient interview.
9	MoU with NGO Hospital	5.00	Signed MoU.
10	Manual of Responsibilities/ Duties prepared and sent out	4.00	Copy of Manual supplied. MOs found to be generally aware of it.
11	Delegation of powers done	6.00	G.O. issued, widely known.
12	Urban areas sub-Plan	12.00	Sub-Plan approved by PMB.
13	50% of MO vacancies filled	7.00	MOs physically in place- check.
14	1Forest CHC+1 Taluk Hospital fully operational as FRU	13.00	Observation, interview with hospital managers, patient interview.
15	New blood storages functional	6.00	Certification, observation.
16	Concurrent evaluation done	3.00	Concurrent evaluation report.
	Total	81.00	

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