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The World Bank

Report No: ICR2318

IMPLEMENTATION COMPLETION AND RESULTS REPORT
(IDA-42270)

ON A

PROPOSED CREDIT

IN THE AMOUNT OF SDR 245 MILLION

(US$360 MILLION EQUIVALENT)

TO THE

REPUBLIC OF INDIA

FOR A

REPRODUCTIVE AND CHILD HEALTH PROJECT II

September 27, 2012

Human Development Unit

South Asia Region

CURRENCY EQUIVALENTS

(Exchange Rate Effective March 31, 2012)

Currency Unit = Rupee
Rupee 50.95 = US$1
SDR 1 = US$0.65

FISCAL YEAR
April 1 - March 31

ABBREVIATIONS AND ACRONYMS

ANC	Ante-Natal Care
ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
BCC	Behaviour change communications
CBR	Crude Birth rate
CES	Coverage Evaluation Survey
CHC	Community Health Center
COSO	Committee of Sponsoring Organizations of the Treadway Commission
CPR	Couple Protection Rate
CRM	Common Review Mission
CSS	Centrally Sponsored Schemes
DCA	Development Credit Agreement
DFID	Department for International Development, Government of UK
DIR	Detailed Implementation Review
DLHS	District Level Household Survey
DP	Donor Partners
DPMU	District Programme Management Unit
EAG	Empowered Action Group
EmONC	Emergency Obstetric and Neonatal Care
EPW	Empowered Procurement Wing
FMG	Financial Management Group
FP	Family Planning
FRU	First Referral Unit
GAAP	Governance and Accountability Action Plan
GMP	Good manufacturing practices
GOI	Government of India
HIV/AIDS	Human Immunodeficiency Virus/ Acquired Immune Deficiency Syndrome
HMIS	Health Management Information System

ICB	International Competitive Bidding
ICDS	Integrated Child Development Services
ICPD	International Conference on Population and Development
ICRR	Implementation Completion and Results Report
IDA	International Development Association
IEC	Information, Education and Communication
IFA	Iron Folic Acid
IMEP	Infection Management and Environment Plan
IMNCI	Integrated Management of Neonatal and Childhood Illness
IMR	Infant Mortality Rate
INT	Institutional Integrity Team
IUD	Intrauterine device
JRM	Joint Review Mission
JSY	*Janani Suraksha Yojana*
MDG	Millennium Development Goals
MIS	Management Information System
MMR	Maternal Mortality Rate
MOHFW	Ministry of Health and Family Welfare
MTR	Mid Term Review
NFHS	National Family Health Survey
NGO	Non Governmental Organization
NMR	Neonatal Mortality Rate
NPSP	National Polio Surveillance Project
NRHM	National Rural Health Mission
PDO	Project Development Objectives
PHC	Primary Health Center
PPP	Public Private Partnerships
PRI	*Panchayat Raj* Institutions
QER	Quality Enhancement Report
QUALP	Quality Assessment of the Lending Portfolio
RCH	Reproductive and Child Health
RKS	*Rogi Kalyan Samiti*
SBA	Skilled Birth Attendance
SC	Scheduled Caste
SPIPs	State Program Implementation Plans
SPMU	State Programme Management Unit
ST	Scheduled Tribe
STD	Sexually Transmitted Diseases
TA	Technical Assistance
TFR	Total Fertility Rate
U5MR	Under-five Mortality Rate

UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VGHP	Vulnerable Group Health Plan
VHSC	Village Health and sanitation Committee

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INDIA
REPRODUCTIVE AND CHILD HEALTH PROJECT II

CONTENTS

D A T A S H E E T

A. Basic Information			
Country:	India	Project Name:	India: Reproductive & Child Health Project II
Project ID:	P075060	L/C/TF Number(s):	IDA-42270
ICR Date:	09/27/2012	ICR Type:	Core ICR
Lending Instrument:	SIL	Borrower:	GOVERNMENT OF INDIA
Original Total Commitment:	XDR 245.00M	Disbursed Amount:	XDR 245.00M
Revised Amount:	XDR 245.00M		
Environmental Category: B			
Implementing Agencies: Ministry of Health and Family Welfare			
Cofinanciers and Other External Partners: UNFPA UK DfID			

B. Key Dates				
Process	**Date**	**Process**	**Original Date**	**Revised / Actual Date(s)**
Concept Review:	12/11/2003	Effectiveness:	11/10/2006	11/10/2006
Appraisal:	01/20/2005	Restructuring(s):		05/04/2010 03/27/2012
Approval:	08/22/2006	Mid-term Review:	08/15/2008	12/05/2008
		Closing:	09/30/2010	03/31/2012

C. Ratings Summary	
C.1 Performance Rating by ICR	
Outcomes:	Moderately Satisfactory
Risk to Development Outcome:	Low or Negligible
Bank Performance:	Moderately Satisfactory
Borrower Performance:	Moderately Satisfactory

C.2 Detailed Ratings of Bank and Borrower Performance (by ICR)			
Bank	**Ratings**	**Borrower**	**Ratings**
Quality at Entry:	Moderately Satisfactory	Government:	Moderately Satisfactory
Quality of Supervision:	Satisfactory	Implementing Agency/Agencies:	Moderately Satisfactory
Overall Bank Performance:	Moderately Satisfactory	**Overall Borrower Performance:**	Moderately Satisfactory

C.3 Quality at Entry and Implementation Performance Indicators			
Implementation Performance	**Indicators**	**QAG Assessments (if any)**	**Rating**
Potential Problem Project at any time (Yes/No):	No	Quality at Entry (QEA):	None
Problem Project at any time (Yes/No):	Yes	Quality of Supervision (QSA):	None
DO rating before Closing/Inactive status:	Moderately Satisfactory		

D. Sector and Theme Codes

	Original	Actual
Sector Code (as % of total Bank financing)		
Central government administration	1	1
Health	97	97
Other social services	1	1
Sub-national government administration	1	1
Theme Code (as % of total Bank financing)		
Child health	29	29
Decentralization	14	14
Health system performance	14	14
Other social development	14	14
Population and reproductive health	29	29

E. Bank Staff

Positions	At ICR	At Approval
Vice President:	Isabel M. Guerrero	Praful C. Patel
Country Director:	Onno Ruhl	Michael F. Carter
Sector Manager:	Julie McLaughlin	Anabela Abreu
Project Team Leader:	Vikram Sundara Rajan	Sadia Afroze Chowdhury
ICR Team Leader:	Meera Shekar	
ICR Primary Author:	Meera Shekar	

F. Results Framework Analysis

Project Development Objectives (from Project Appraisal Document)
To expand the use of essential reproductive and child health services of adequate quality with reduction of geographical disparities.

Revised Project Development Objectives (as approved by original approving authority)

During restructuring in 2010, the PDO was not changed but PDO indicator # 5 was revised to measure at least 80% coverage in high-risk districts instead of polio eradication (as below). In addition, three intermediate outcome indicators were revised and one added, while three original indicators were dropped. The data below reflects information on the revised set of indicators as well as the original.

(a) PDO Indicator(s)

Indicator	Baseline Value	Original Target Values (from approval documents)	Formally Revised Target Values	Actual Value Achieved at Completion or Target Years
Indicator 1 :	% of eligible couples using any modern contraceptive method			
Value quantitative or Qualitative)	Permanent Methods:34; Spacing Methods:11; Overall: 45; SC/ST: SC-43; ST-39; EAG States 33; Lowest Wealth Quintile : 36.4	Permanent Methods:36; Spacing Methods:16; Overall:52; SC/ST: 45; EAG States:40; Lowest Wealth Quintile: NA		Permanent Methods: 35; Spacing Methods: 12; Overall: 47.1, SC/ST: (SC 49, ST : 42); EAG States: 4 out of 8 states achieved target by mid-line; Lowest Wealth Quintile: 35
Date achieved	08/22/2006	09/30/2010		03/31/2010
Comments (incl. % achievement)	As per DLHS 3 (2007-08), 19 of 34 states had achieved the overall target of 52% by mid-line, of which 4 are from the weakest EAG states. Significant improvements are also documented among SC and ST populations by mid-line. Latest data from DLHS 3.			
Indicator 2 :	% of deliveries conducted by skilled providers			
Value quantitative or Qualitative)	Overall:48; SC/ST :35(SC-39.6, ST-28.4); EAG States: 32; Lowest Wealth Quintile: 27.5	Overall: 60; SC/ST: 45; EAG States: 45; Lowest Wealth Quintile: NA		Overall: 76.2%; SC/ST (SC-75.7; ST-61.3); EAG States: 65.6; Lowest Wealth Quintile: 47.9
Date achieved	08/22/2006	09/30/2010		03/31/2010
Comments (incl. % achievement)	Latest data from CES 2009. Target over-achieved. Progress substantiated by field visits by the ICR team in two states MP and Karnataka. Target surpassed substantially in both SC and ST populations and EAG states at midline.			
Indicator 3 :	% of 12-23 months children fully Immunized			
Value quantitative or Qualitative)	Female: 44; Male : 45; Overall : 45; SC/ST SC-41.9 ST-36.5; EAG States: 28; Lowest Wealth Quintile: 31.3	Female: 75; Male: 75; Overall :75; SC/ST :75; EAG States: 60; Lowest Wealth Quintile: NA		Female:59.9; Male:61.9; Overall:54.1; SC/ST: (SC-58.9; ST-49.8); EAG States: 61; Lowest Wealth Quintile: 47.3
Date achieved	08/22/2006	09/30/2010		03/31/2010
Comments	Latest data from CES 2009. Female: Substantial progress by 2007-8; Male: about 50%			

(incl. % achievement)	of target achieved by 2009. Overall: 12 states achieved target by 2007-08, including two EAG states. Substantial progress; about 56% and 35% of target for SC/ST by 2009.			
Indicator 4 :	% of mothers and newborns visited within 2 weeks of delivery by a trained worker.			
Value quantitative or Qualitative)	greater than 10	20		49.7 (2007-08)
Date achieved	08/26/2006	09/30/2010		03/31/2012
Comments (incl. % achievement)	Target substantially over-achieved.			
Indicator 5 :	At least 80% of households with eligible children covered during national & sub-national immunization days in high risk districts			
Value quantitative or Qualitative)	NA			98
Date achieved	08/22/2006	09/30/2010		03/31/2012
Comments (incl. % achievement)	This indicator was modified during restructuring and a target set. Target over-achieved and substantially surpassed. India has been certified by WHO as having achieved polio-free status as of Jan 2012; Validated data from National Polio Surveillance Project (NPSP) covering 1% of households			

(b) Intermediate Outcome Indicator(s)

Indicator	Baseline Value	Original Target Values (from approval documents)	Formally Revised Target Values	Actual Value Achieved at Completion or Target Years
Indicator 1 :	Number of states/UTs successfully completing institutional mobilization phase			
Value (quantitative or Qualitative)	15	Yr 1 : 35		35
Date achieved	08/22/2006	09/30/2010		03/31/2008
Comments (incl. % achievement)				
Indicator 2 :	% of State plans with specific activities to reach vulnerable groups			
Value (quantitative or Qualitative)	NA	75%		100%
Date achieved	06/08/2006	09/30/2010		03/31/2009
Comments (incl. % achievement)	Specific activities are part of all state PIPs. This indicator was revised during restructuring.			
Indicator 3 :	% of States reporting quarterly financial performance/annual audit reports in time			
Value (quantitative or Qualitative)	NA	100%		60%
Date achieved	08/22/2006	09/30/2010		03/31/2012
Comments	Indicator revised from districts to states at restructuring.			

(incl. % achievement)				
Indicator 4 :	% of district not having at least one month stocks of critical inputs			
Value (quantitative or Qualitative)	NA	Greater than 5%		0%
Date achieved	08/22/2006	09/30/2010		03/31/2012
Comments (incl. % achievement)	JRM-8, July-September 2010 indicate that essential drugs were available at most facilities visited. In some states like MP, States have put in place their own procurement systems.			
Indicator 5 :	% of 24 hrs. PHCs conducting more than 10 deliveries per month			
Value (quantitative or Qualitative)	NA	60%		38.1%
Date achieved	08/22/2006	09/30/2010		03/31/2008
Comments (incl. % achievement)	38.1% at DLHS-3 (2007-08) against target of 60%			
Indicator 6 :	% of districts (in EAG states+Assam) having the following: (i) District hospitals conducting at least 20 C-Section in a quarter. (ii) At least one sub-district hospital conducting 10 C-section in a quarter.			
Value (quantitative or Qualitative)	NA	(i) 100%; (ii) 100%		(i) 50%; (ii) 40%
Date achieved	08/22/2006	09/30/2010		12/31/2011
Comments (incl. % achievement)	2011 data (in %) based on Quarterly reports from HMIS Q1 Q2 Q3 Districts 51.7 50.8 49.1 Sub-Districts 16.0 40.0 40.9 This indicator was revised during restructuring			
Indicator 7 :	% of districts conducted training in the last three months for (i) SBA; and (ii) IMNCI			
Value (quantitative or Qualitative)	NA			(i) 55%; (ii) 35%
Date achieved	08/22/2006			03/31/2012
Comments (incl. % achievement)	422 districts reporting data. Indicator added during restructuring			
Indicator 8 :	Number of states/UTs contracting non-government sector to improve delivery of essential RCH services			
Value (quantitative or Qualitative)	NA	15 states		25 states
Date achieved	08/22/2006	09/30/2010		03/31/2010
Comments (incl. %	Nearly all states contract non Govt sector, for different services.			

achievement)				
Indicator 9 :	% of EAG and NE states visited by the MOHFW State facilitation teams			
Value (quantitative or Qualitative)	NA	Yr 1: 50%; Yr 2 : 75%; Yr 3 :100%; Yr 4 :100%		Yes
Date achieved	08/22/2006	09/30/2010		03/31/2009
Comments (incl. % achievement)	100%			
Indicator 10 :	% of EAG and NE states visited by the MOHFW State facilitation teams			
Value (quantitative or Qualitative)	NA	Yr 1: 50%; Yr 2 : 75%; Yr 3 :100%; Yr 4 :100%		Yes
Date achieved	08/22/2006	09/30/2010		03/31/2009
Comments (incl. % achievement)	100%			
Indicator 11 :	Timely completion of mid and end line surveys and studies			
Value (quantitative or Qualitative)	NA	Yr 2 Midline survey; Yr end End-line survey		NA
Date achieved	08/22/2006	09/30/2010		03/31/2012
Comments (incl. % achievement)	End line survey (DLHS-4) delayed. Report likely in 2013			
Indicator 12 :	Non-polio acute flaccid paralysis rate of at least one per 100,000 children below 15 years			
Value (quantitative or Qualitative)	AFP rate 3.4;	AFP rate greater than 1		6.32
Date achieved	08/22/2006	09/30/2010		02/25/2012
Comments (incl. % achievement)				
Indicator 13 :	Stool Samples collected from at least 80% of acute flaccid paralysis cases within 14 days			
Value (quantitative or Qualitative)	82%	Greater than 80%		Two specimens 89%; One specimen 98%
Date achieved	08/22/2006	09/30/2010		02/25/2012
Comments (incl. % achievement)				

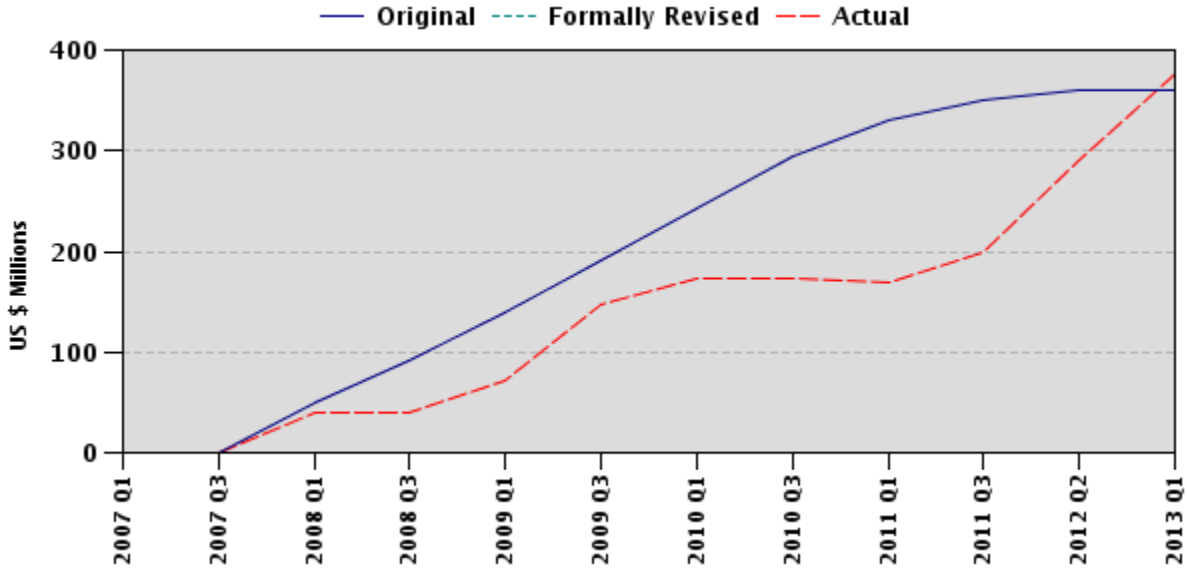
G. Ratings of Project Performance in ISRs

No.	Date ISR Archived	DO	IP	Actual Disbursements (USD millions)
1	12/15/2006	Satisfactory	Satisfactory	0.00
2	06/07/2007	Moderately Satisfactory	Moderately Satisfactory	0.00
3	12/06/2007	Moderately Satisfactory	Moderately Satisfactory	40.00
4	06/04/2008	Moderately Satisfactory	Moderately Unsatisfactory	40.00
5	12/23/2008	Moderately Unsatisfactory	Moderately Unsatisfactory	71.15
6	06/26/2009	Moderately Satisfactory	Moderately Unsatisfactory	173.05
7	08/24/2009	Moderately Satisfactory	Moderately Unsatisfactory	173.05
8	04/13/2010	Moderately Satisfactory	Moderately Satisfactory	172.77
9	06/19/2010	Moderately Satisfactory	Moderately Satisfactory	169.88
10	02/06/2011	Moderately Satisfactory	Moderately Satisfactory	198.72
11	08/09/2011	Moderately Satisfactory	Moderately Satisfactory	198.72
12	04/12/2012	Moderately Satisfactory	Moderately Satisfactory	290.91

H. Restructuring (if any)

Restructuring Date(s)	Board Approved PDO Change	ISR Ratings at Restructuring		Amount Disbursed at Restructuring in USD millions	Reason for Restructuring & Key Changes Made
		DO	IP		
05/04/2010	N	MS	MS	172.77	Update results framework to adjust some targets; 4 indicators (1 PDO and 3 intermediate) were revised, 1 new Intermediate outcome indicator (Details in section 1.3) was added, and three Intermediate outcome indicators were dropped. Implementation plans were adjusted to accommodate impact of post-DIR changes in fiduciary rules while still providing the flexibility required by the project on disbursement and implementation. Disbursement for polio operational costs was allowed. Project was extended to March 2012.
03/27/2012		MS	MS	290.91	Reallocation of credit.

I. Disbursement Profile



1. Project Context, Development Objectives and Design

1.1 Context at Appraisal

India experienced rapid gains in social indicators in the decade preceding project appraisal – literacy increased from 52% in 1991 to 65% in 2001, infant mortality rate (IMR) declined from 84 per 1,000 live births in 1990 to 58 in 2004, and the annual population growth rate fell to below 2%. Despite these gains, there were persistent reasons for concern. Poverty rates became geographically concentrated with almost a half of the poor living in three states: Uttar Pradesh, Bihar and Madhya Pradesh. IMR remained high and there was no significant decline in the Maternal Mortality Rate (MMR). Population growth continued at relatively high levels because of a large proportion of the population in the reproductive age, an unmet need for contraception and other socio-economic factors. Gender bias as evidenced by the declining sex ratio continued to be high; and regional imbalances continued to be a challenge, with the National Family Health Survey (NFHS) 1998-99 showing that child deaths were concentrated in a few states such as Madhya Pradesh, Uttar Pradesh and Orissa.

Historically, the Ministry of Health and Family Welfare (MOHFW) had focused on reducing fertility through setting specific family planning targets. However, over time, the government's family welfare health program had extended its scope to include reductions in maternal and child mortality and morbidity, as well a broader approach to contraception. The Reproductive and Child Health (RCH) I program was launched in 1997, with support from a wide-range of Development Partners (DPs) including the European Union (EU), the United States Agency for International Development (USAID), the United Nations Children's Fund (UNICEF), the Department for International Development (DfID), the World Bank, and others supporting all or part of the program. In April 2005, while preparation for the RCH II project was ongoing, the Government of India (GOI), in pursuance of its commitment to enhance investment in the health sector from 0.9% to 2-3% of GDP, launched the National Rural Health Mission (NRHM), with a strong focus on reducing infant and maternal mortality, providing universal access to public health services, prevention and control of both communicable and non-communicable disease, ensuring population stabilization, and maintaining gender balance. While the NRHM remains a nation-wide initiative, it maintains a focus on 18 states with weaker health infrastructure and health outcomes.

The Bank has partnered with GOI in the Family Welfare Program since 1972. Until 1997, this involved supporting states to expand their rural health care infrastructure and strengthen in-service training and a strong focus on achieving ambitious family planning targets. In 1997, through the RCH I project, the Bank supported GOI in making the paradigm shift away from this target-driven approach for family planning. The years 2005-06 marked a turning point for the health sector in India with the launch of the national flagship NRHM, and the adoption of an explicit health financing goal. Further, there was also an unprecedented paradigm shift towards out-put based financing for states, and a new emphasis on innovations in service delivery and results on the ground.

The RCH II project built on the many lessons learned from RCH I by being more proactive in addressing difficult policy and operational issues, strengthening critical institutional and management capacities at national and decentralised levels, allocating flexible funds for

innovations at the state and district levels, increasing state ownership of the program, and better coordination with donor partners (DPs). RCH II was co-financed by DFID, UNFPA, and IDA as pooling partners, with other partners such as the EC, USAID and UNICEF supporting similar objectives outside the program, without pooling funds.

1.2 Original Project Development Objectives (PDO) and Key Indicators

The PDO in the PAD is "*To expand the use of essential reproductive and child health services of adequate quality with reduction of geographical disparities*". However, in the Development Credit Agreement (DCA), the PDO is slightly differently worded as "*The objective of the Project is to support the Borrowers' continuing program for reproductive and child health (the RCH II program) that aims to achieve reductions in maternal mortality and child mortality"*. The two stated objectives are clearly intrinsically linked although the PDO in the PAD is more specific regarding how the overall RCH II Program objective will be met, i.e. by expanding the use of services, with a focus on reducing inequities. Given the fact that the project was supervised and monitored on the basis of the PDO in the PAD, this ICR assessment is based on this statement of the PDO.

Original PDO indicators in the PAD were, as follows: "disaggregated by geography, caste and gender:

(i) % of eligible couples using any modern contraceptive method;
(ii) % of deliveries conducted by skilled providers (doctors, ANMs, nurses);
(iii) % of mothers and newborn children visited within 2 weeks of delivery by a trained community level health worker;
(iv) % of 12-23 month children fully immunized; and
(v) polio free status achieved. "

1.3 Revised PDO (as approved by original approving authority) and Key Indicators, and reasons/justification

There was no revision of the PDO. However, during Project Restructuring (May 2010), the Results Framework (RF) was changed as follows (see table below): 4 indicators were revised [1 PDO (#5), 3 Intermediate], 1 new Intermediate Outcome indicator was added and three Intermediate Outcome indicators were dropped. The restructuring also clarified data sources and frequency of reporting for some indicators. The following is the summary of the changes made:

Original indicator	Change	Revised/new indicator
PDO indicator		
Polio free status achieved	Revision of indicator to focus on coverage in high risk districts	At least 80% of households with eligible children covered during national and sub-national immunization days in high risk districts
Intermediate indicators		
% of districts plans with specific activities to reach vulnerable groups	Revision of indicator to improve quality of reporting as district reporting is a necessary requirement for state reporting	% of state plans with specific activities to reach vulnerable groups
% of districts reporting quarterly financial performance/annual audit reports in time	Revision of indicator to improve quality of reporting as district reporting is a necessary requirement for state reporting	% of states reporting quarterly financial performance/annual audit reports in time

% of upgraded FRUs offering 24 hour emergency obstetric care	Revision to focus on access in the most lagging states	% of districts (in EAG+Assam) having the following: (i) District hospitals conducting at least 25 C-sections in a quarter; (ii) At least one sub-district hospital conducting 10 C-sections in a quarter
Indicators dropped		
% of sampled outreach sessions where guidelines for AD syringe use and safe disposal are followed	Dropped as data sources unable to capture indicator reliably. This will be monitored during field visits of review missions.	
% of districts that were able to implement M&E triangulation	Dropped as data sources unable to capture indicator reliably. The new HMIS is being spearheaded under the NRHM and building capacity for data analysis and triangulation is part of the roll out.	
Mechanisms for performance awards in place	Dropped. With the NRHM providing an equally huge resource envelope s RCH II pool, this may not provide the same incentive as was envisaged during project design – it may also end up providing greater resources to well performing states and hence divert resources from states that require them the most.	
Additional indicator		
Intermediate indicator	Additional indicator to monitor progress in training of human resources	% of districts conducting training in the last three months for SBA and IMNCI

1.4 Main Beneficiaries

The primary target group for the project included all eligible women and children, as well as couples in the reproductive age group across India, with a special focus on the poor, thereby reducing geographical disparities. Since more than 50% of the poor in India lived in just three states – Uttar Pradesh, Bihar and Madhya Pradesh – the project acknowledged that progress on key indicators in these three states plus the remaining five states with poor maternal and child health status collectively termed the Empowered Action Group or EAG states (which include Bihar, Chhattisgarh, Jharkhand, MP, Orissa, Rajasthan, UP, and Uttarakhand) would be critical for achieving the goals of the project. The project, therefore, had a special focus on poor women and children in these eight EAG states. Over time, additional attention was also directed at the vulnerable North-Eastern states. In addition, the project focused on several vulnerable groups with a view to enhancing their access to quality RCH services.

1.5 Original Components

The project had three components:

Project Component 1: Improvement of Essential RCH Services (US$1,367 Million)

Sub-component 1.1: Activities administered by MOHFW: This sub-component included several activities which were to be managed largely by MOHFW, including: (i) procurement of goods and services, particularly pharmaceuticals, medical supplies and equipment for the RCH II program; (ii) routine immunization, including purchasing and distributing vaccines, purchasing,

distributing and maintaining the cold chain equipment, and carrying out other activities to strengthen routine immunization across the country; (iii) behavior change communication (BCC) to disseminate information and change behaviors; (iv) training and enhancement of human resources, skills and capacities for implementing the program; (v) expanding public private partnerships, and playing a proactive role in terms of providing advice and technical support to the states in this area; and (vi) policy development and pilots such as an accreditation scheme for private providers, social franchising, innovative financing of schemes through vouchers and social risk funds and so on.

Sub-component 1.2: Innovative and developmental activities in State Project Implementation Plans (SPIPs): This sub-component included all innovative activities to be included by states/union territories in their SPIPs, and provided 'flexible funds' to support creativity by the states. Although the activities could not be defined ex-ante, they were generally meant to encompass creative initiatives to expand access to family planning, safe motherhood services, new-born care, community-based child health and nutrition programs, promotion of health and development of adolescents, urban RCH care and service provision to tribal and scheduled caste populations.

Project Component 2: Technical Assistance, Monitoring and Evaluation (US$26.7 Million)

Sub-component 2.1: Technical Assistance (TA): MOHFW aimed to establish the National Health Systems Resource Center (NSHRC), with an advisory board comprising representatives from MOHFW and various DPs to harmonize TA. The TA program under RCH II was to be two-fold: to support states (especially EAG and North-Eastern states) in the planning process, and to support GOI's comprehensive Governance and Accountability Action Plan (GAAP) to strengthen procurement capacity of both MOHFW as well as the selected qualified procurement agent/UN agency. This component was also supported by parallel financing from DFID, under a plan agreed upon jointly by GOI, DFID and IDA.

Sub-component 2.2: Monitoring and Evaluation: This sub-component was designed to support a comprehensive M&E system to closely and regularly monitor progress towards indicators laid out in the Results Matrix, including repeat rounds of the Reproductive and Child Health Rapid Household Survey (in 2001-2002, 2006-07, and 2009-10), implementation of special studies and special surveys particularly for tracking polio eradication. This activity was implemented as part of the main RCH II program.

Project Component 3: Polio Eradication (US$829 Million)

India's polio eradication activities began in 1995, with the goal to eradicate polio by 2001. However, due to resource constraints and competing priorities, this goal was not achieved. The funding under RCH II was part of an overall plan of GOI to put together a total of US$829 million from various DPs to bridge the financing gap for achieving polio-free status, a precursor to polio eradication, by 2007, with subsequent supplemental surveillance activities for a few years after, in order to declare polio eradication.

1.6 Revised Components

Project components were not revised.

1.7 Other significant changes

As mentioned above, the RF was revised during the May 2010 restructuring. The restructuring focused on the following: (i) reallocating the proceeds of the Credit to category 2 for polio operating costs; (ii) disbursing polio operating costs based on number of children immunized at standard unit costs; (iii) extending the Closing Date of the project by 18 months (from September 30, 2010 to March 31, 2012); (iv) revising the Results Framework, and (v) updating of the implementation schedule and agreement that RCH II would be implemented until March 31, 2012 under the umbrella of the NRHM. The Development Credit Agreement (DCA) was amended twice in the life of the project in March and October 2008 to reflect some of these changes.

2. Key Factors Affecting Implementation and Outcomes

2.1 Project Preparation, Design and Quality at Entry

Lessons learned and incorporated into project design: The design of RCH II was informed by over twenty background studies, and most importantly, the ICR of the RCH I project which identified important gaps: (i) there was insufficient flexibility in funds provided to the states, resulting in poor responsiveness to state-level needs and hence weak state ownership of the program; and (ii) inputs from various DPs as well as government departments were not harmonized, straining the limited management and implementation capacities at the state and district levels. Other lessons learned included the perils of a non-flexible "one size fits all" design, the lack of specific focus on poor performing states, the need to ensure state ownership and capacity building as well as lack of an effective donor coordination mechanism. The design of RCH-II sought to address these by: (i) empowering states to flexibly manage funds in response to locally identified needs as reflected in District Program Implementation Plans and State Program Implementation Plans; (ii) emphasizing state-level accountability for outcomes by putting in place a Memorandum of Understanding between GOI and individual states, thus enhancing state responsibility and ownership; (iii) bringing about better programmatic convergence between the RCH and other programs such as the National AIDS Control Program and programs of the Department of Women and Child Development; (iv) building effective donor coordination mechanisms and Joint Review Missions; and (v) strengthening implementation capacity through institutional reforms and technical assistance for better program planning/management, finance and monitoring. Key to this was the eventual establishment of the National Health Systems Resource Center under the project.

Besides this, the project incorporated important initiatives to further enhance access to RCH services, including: (i) a pro-poor focus, by weighting funding in favor of the EAG and North-Eastern states which were generally worse off than other states in terms of not only MCH outcomes, but also poverty and other socio-economic indices; (ii) states were required to incorporate pro-poor and gender strategies in SPIPs; (iii) activities for urban areas were also included in the design; and (iv) a greater emphasis was placed on public private partnerships to make RCH services more widely available and to improve their quality.

Quality at Entry: A QER was held in December 2004 that raised several issues, all of which were addressed as project design matured. In November 2008, a QALP assessment concluded

that the probability of achieving the DO is Moderately Likely in spite of the major problems encountered during project implementation. The assessment also rated the quality of design, focus on development effectiveness and fiduciary/safeguard aspects as Satisfactory, and supervision and candor/realism of ISRs as Moderately Satisfactory.

Implementation Readiness: The task team had ensured the following implementation readiness steps so that implementation could begin as soon as the project was approved: (i) establishment of a process for the preparation and appraisal of State project Implementation Plans (SPIPs), with 16 SPIPs already appraised by the MOHFW in 2006, ensuring state ownership and initiation of decentralized planning; (ii) A Governance and Accountability Action Plan (GAAP) developed by GOI had been developed, shared with and agreed to by the pooling partners; (iii) procurement plans for ICB contracts for the first 18 months of project implementation had been developed and shared with pooling partners; (iv) the IMEP and VGHP had been prepared and publicly disclosed; (v) financial arrangements at the center and states had been established; (vi) the budget for the first two years of the project (2005/06, 2006/07) were approved and released to the states; (vii) results monitoring indicators had been agreed and baseline data was to be provided by the RCH rapid household survey (2000-01); and (viii) an MOU between GOI and the pooling partners had been finalized. All of these have since been adopted as standard readiness filters.

Assessment of Risk: Critical risks and possible controversial aspects were identified and mitigating measures were incorporated into project design. These included: (i) issues associated with funds flow and disbursement. The project included greater decentralization of decision-making to allow responsiveness to funding needs, going hand-in-hand with a more rigorous approach to state accountability for use of funds; (ii) poor capacity for management, planning and monitoring. The project had undertaken an Institutional Assessment, based on which a systematic capacity development plan was developed, to be rolled out in three phases; (iii) issues associated with challenges to access, including loss of choice and ability to exercise voluntary acceptance in a highly focused family planning program, and inability of states to identify the districts most vulnerable to failing to address the maternal and child health needs of their populations. The project strongly re-affirmed its commitment to voluntarism in the adoption of contraception, and incorporated it into their BCC program; and also set specific criteria for State Project Implementation Plans (SPIPs) to explicitly identify districts with the poorest health outcomes and incorporate strategies to address this; (iv) issues associated with procurement and financial management capacity. The GAAP agreed to by GOI put in place several measures to strengthen procurement implementation, contract monitoring and quality management; and financial management capacity was to be strengthened through greater financial delegation to district Societies and improved staffing.

Participatory Processes: A Social Assessment was completed during project preparation to appraise the RCH II program's framework and its implementation processes at state and district levels, through identifying and developing strategies to address the needs of underserved populations and ensuring social and gender equity. This was done through a series of workshops and focus group discussions involving beneficiaries, NGOs, private providers, civil society, DPs, and state and district level health staff.

Detailed Implementation Review (DIR):
This review of health sector operations in India was triggered by concerns about possible fraud and corruption in procurement under the First Reproductive and Child Health (RCH1) Project. In May 2000, the South Asia Region reported these concerns to INT. In turn, INT undertook an investigation and issued its report in March 2005. This led to the DIR of five health projects. The DIR was formally initiated in September 2006, completed in October 2007, and made public in January 2008. Preparation for the RCH II project started in 2003, the project processing was put "on-hold" while the RCH I investigations was ongoing, and approved in August 2006.

2.2 Implementation

Project Start-up: The project was appraised in April 2005, approved in August 2006 and was effective in November 2006, about the same time as the DIR was initiated. RCH II program was launched in April 2005. This delay of 14 months between completion of project preparation and Board approval was to allow for the completion of an INT review of allegations of corruption in procurement under RCH I. This made the engagement challenging and also caused a loss of momentum for project start-up which was further aggravated by the launch in the interim (in April 2005) of the GOI's flagship National Rural Health Mission (NRHM), which included a strong focus on RCH, the expansion of the NRHM flexipool and the resurgence of polio cases that shifted MOHFW's focus away from RCH II. The Bank team therefore needed extensive efforts to re-engage with MOHFW and reaffirm the commitments of RCH II.

The results from the DIR were released publicly in 2008 after an investigation. The GOI response to this was strong at both the central and state levels. Several implementation issues were encountered subsequently: the slow implementation progress on procurement, FM and household surveys with stringent post DIR oversight requirements resulted in unsatisfactory rating of implementation progress. Bank financing was limited to operational costs, and disbursement for decentralized activities was low. This strong focus on fiduciary scrutiny crowded out the technical dialogue, and further strained the relationship with the pooling partners (GOI, DfID, UNFPA and the Bank). Policy dialogue and prioritization of agreed actions were difficult in this environment. As part of the response, a COSO workshop was held with all the pooling partners to rebuild trust and rapport, and agreement was reached to move forward collectively with government.

In response to the DIR, a Joint Action Plan (JAP) was designed during implementation to rectify weaknesses identified by the DIR. The Action Plan comprised five sets of activities: (i) health sector measures, agreed jointly with the Government of India (GOI), to remedy and/or mitigate risks to fraud and corruption and other deficiencies in the five projects in the DIR (four of which had closed by the time the report was issued) plus the eight on-going health operations; (ii) India Program wide measures to address potential weaknesses including fiduciary systems; (iii) Region wide measures to increase awareness and share the lessons of the DIR with other countries in South Asia; (iv) Bank wide measures undertaken by the Bank's central policy and health units, OPCS and HNP, to mitigate the risks in health operations more generally and incorporate the lessons of the DIR in the Bank's operations; and (v) specific investigations by the Bank's Integrity Department (INT) of possible fraud and corruption identified by the DIR.

The GOI and state governments worked to address weaknesses in: (a) M&E and financial management; (b) mechanisms for selection and oversight of NGOs; (c) strengthening decentralized procurement; and (d) and centralized procurement. Considerable progress was made, notably in the introduction of performance audits, monitoring mechanisms and MIS, the introduction of third party monitoring, complaint and redressal mechanisms, and strengthening selection and oversight of NGOs. Centralized procurement was strengthened and the use of the United Nations Office of Project Services (UNOPS) as a central procurement agent resulted in more efficient procurement and facilitated better oversight of quality, while the Government launched e-procurement systems (that are operational in some states such as Karnataka wherein procurement times have also been reduced considerably) and proposed to establish a central procurement agency (CPA). Certification of TNMSC in the state of Tamil Nadu and capacity building efforts in other states contributed to strengthening of decentralized procurement.

While these actions have strengthened fiduciary and implementation capacities, the DIR, as it was implemented challenged RCH II project implementation. Concerns about the possibility of future investigations remained. Within this climate, engaging clients on the broader governance agenda, including value for money and effectiveness of public services remained a challenge.

Implementation arrangements for RCH II built upon lessons from RCH I. Despite this, several on-going issues led to initial delays in implementation of RCH II. These included: (i) poor coordination between PMUs at the state and central levels; (ii) high attrition rates among PMU staff, either due to frequent transfers or quitting because of low compensation and lack of authority; (iii) SPMU/DPMU staff largely focused on compilation of data and reporting, with limited role in providing technical inputs; (iv) poor coordination between the NSHRC and RCH divisions, and limited involvement of DPs in the NSHRC; and slow start in the establishment of SHSRCs; (v) slow progress on convergence between RCH and ICDS and HIV/AIDS, two programs which were considered to be highly relevant for the RCH program.[1] The subsequently integration of RCH with NRHM placed a heavy management burden on the State and District-level PMUs.

Political commitment to the RCH program at the central level was high, with strong leadership at the national level and growing enthusiasm shown by a number of states: this was reflected in the increased momentum of project implementation from early-2008. Still, there were many issues relating to program management which led the implementation performance rating to be retained at MU, due to slow disbursement rates. In addition, progress was slow on important management positions such as the state facilitation teams, the Director for Human Resource Management and Governance, focal points for waste management and those for inter-sectoral coordination. In 2009, a decision was taken to enhance program management by further strengthening the coordination between RCH and NRHM by having a common review for both programs (by combining the JRM and CRM of the NRHM) and having the JRM jointly chaired by the Program Directors of RCH and NRHM. With improved staffing at both central and state levels, there was a conscious shift towards focusing on quality of care, and DPs provided substantial TA to the states for this purpose.

[1] Mid-Term Review: Thematic Report on Programme Management and Monitoring; Progress (2005-08), Key Issues and Way Forward; Donor Coordination Division, MOHFW; March 2009.

A Joint Review Mission (JRM) of DPs in January 2007, indicated that implementation was picking up slowly, with initial problems relating to procurement and financial management. Progress was also uneven between states, with EAG states being particularly of concern. Due to delays in implementing the District-Level Household Survey III (DLHS III) survey, the DPs agreed to delay the Mid-term review (MTR) scheduled for July 2007 by a year. The 4th The JRM, held in July-August 2007, noted that RCH-II State and District Program Management Units had been charged with managing NRHM activities as well, which had increased the workload and also caused confusion, since procurement and financial guidelines for the two programs were different. Some important actions were completed, such as contracting of UNOPS as the procurement agent, and updating program guidelines for child health, nutrition etc. Over a 100 innovations had been initiated in various states to enhance uptake of RCH services; and the *Janani Suraksha Yojana* (JSY) (a cash transfer scheme to encourage women to deliver in health facilities) had been launched. A major setback was the delay in undertaking the DLHS-3 and DLHS 4, which seriously hampered the states' ability to analyze and use the data for identifying gaps in service provision and take appropriate corrective action. The 5th JRM, held in January/February 2008, soon after the release of the DIR, noted the impact of the DIR on the dialogue on RCH II. In mid-2008, implementation performance was downgraded to Moderately Unsatisfactory (MU) largely due to continued poor FM, lack of progress on DLHS 3 and continued delays in central procurement.

Mid-Term Review: The MTR was conducted between September and December 2008, led by MOHFW. It included data analysis, state reports, thematic reviews and in-depth field visits. The MTR concluded that, with the increasing pace of implementation, RCH II was poised to make significant, 'if not impressive', improvements in MMR, IMR and TFR. Program management arrangements at central and state levels were found to be substantially in place, and there was evidence of strong central leadership. A paradigm shift was underway, with greater emphasis on outcomes in monitoring; increasing evidence of bottom-up planning; greater use of flexibility in trying out innovative strategies; and greater emphasis on community ownership and measures to ensure equity in service utilization. Technical strategies aimed at easing both demand and supply side constraints were found to have been effective: provision of Emergency Obstetric Care through operationalizing 24x7 PHCs and FRUs, as well as the increasing number of beneficiaries accessing JSY (739,000 in 2005-06 to 7,329,000 in 2007-08 – a ten-fold increase) had contributed to increased institutional deliveries; referral transport systems were in place in most states; and training of personnel had improved quality of care for EmONC, IMNCI and FP. BCC was seen to be proceeding well, with national and state level strategies in place. Program monitoring was undertaken regularly, with successive JRMs as well as availability of both NFHS-3 and DLHS-3 data; MOHFW had also rationalized indicators and web-based national MIS had been launched. However, several major concerns persisted: Problems in the posting, retention and capacity building of staff were noted; as well as gaps in the use of data for decision-making. The MTR also emphasized the need for further attention to quality of care aspects through better training and monitoring/assessment. There were persistent problems with timely procurement of goods; and financial management was suffering due to gross understaffing resulting in poor supervision of states. Although BCC seemed to be progressing, there was limited capacity for strategic communications planning and monitoring, and BCC activities were not adequately linked with the program; use of survey data in monitoring and decision-making

continued to be poor; and gender and equity measures were variably understood and implemented.

Project Restructuring: Following the recommendations of the COSO workshop in 2008, the MTR and discussions with the MOHFW and pooling partners, it was agreed in late 2009 that the project would be restructured to bring about better re-alignment with the NRHM, create greater space for technical and program dialogue (which had been crowded out due to fiduciary issues and inability to disburse), and streamline donor participation to prioritize agreed program actions. Also, despite progress on PDOs, disbursements continued to be low for several reasons: (i) an agreement that only operating costs would be reimbursed at state and district levels due to difficulties at those levels in following procurement procedures; (ii) the Bank's decision to allow pooling partners to disburse their annual lapsable grant ahead of the IDA Credit; (iii) reporting of RCH II expenditures under the NRHM financing pool when items were common to both programs; and (iv) delays in using the services of the procurement agent.[2] The project was restructured in July, 2010, with several changes made, as described earlier, in section 1.7. Implementation and disbursement picked-up subsequently and as of August 2012, the project is fully disbursed. The ICR author believes that based on available information, the project could potentially have been restructured earlier; however, the post-DIR programming environment was not conducive for restructuring and the task team made a conscious and very pragmatic decision to delay restructuring to a more appropriate time.

By 2010, improvements in program management were being reflected in better coordination between RCH II and NRHM, as well as greater participation of DPs in the NRHM CRM. Subsequently, in response to continuing concerns regarding quality of care, MOHFW identified 264 high focus districts with poor health indicators, developing a plan for strengthening supportive supervision in these districts, and preparing district-specific plans for addressing the key inputs and actions needed in these districts. District-level infrastructure has also improved considerably. Paul et al[3] reported that in 2003 for example, only 32% of PHCs and 63% of CHCs were found to have adequate infrastructure. By 2007-08, the situation had improved considerably, with 65.2% of CHCs in the country having functioning Operating Theaters and almost 70% of district hospitals having a functional blood bank. This is significant progress, albeit some gaps still remain as the country moves towards achievement of overall RCH goals. These include, among others, universal availability of safe water (a basic necessity) and where needed generators for ensuring regular power and water supply in health facilities, well designed labor rooms, equipment and facilities for neo-natal resuscitation, and C-section services.

2.3 Monitoring and Evaluation (M&E) Design, Implementation and Utilization

M&E Design: M&E under the project was designed around the Reproductive and Child Health Surveys (baseline established in 2000-01; to be repeated in 2006-07 and again in 2009-10), complemented by data from service statistics and community consultations, to be compiled more

[2] RCH II Restructuring Paper; July 2010.

[3] Paul VK et al. Reproductive Health, and Child Health and Nutrition in India: Meeting the Challenge. India: Towards Universal Health Coverage 2; The Lancet; January 2011.

frequently than the surveys. The causal chain, as designed, from inputs to outputs to results was logical and based on sound technical evidence and program experience in the Indian context. The choice of service-delivery indicators was adequate, and while there were a manageable number of PDO indicators (five), there were a large number of intermediate/process indicators, data for most of which was expected from monitoring reports. No external project evaluation planned or implemented, and the project was solely dependent on the RCH surveys (which were later replaced by the DLHS surveys by GOI) and the DLHS surveys that have been delayed. Although the research designs, sample sizes etc for these surveys were carefully designed, this weakness in M&E detracts from the project.

During implementation, the MOHFW and DPs agreed to a joint mechanism for monitoring, with Joint Review Missions (JRMs) to be undertaken every 6 months, and the first JRM was undertaken in February 2006, even before project launch. Annual Joint Program Reviews were undertaken with a view to bringing together data from various sources, with a mid-term review (scheduled for 2007, and completed in 2008) to provide in-depth assessment of program performance. In-between, it was agreed that MOHFW and DPs would conduct reviews of individual states. Funding of SPIPs was partially tied to their performance.

Mid-term Assessment: At the MTR, a thematic report on program management and monitoring was issued as one of the series of thematic reviews conducted by the joint MOHFW/DPs/Bank team. The review concluded that monitoring of the RCH II program had strengthened since its inception. There had been a general strengthening of manpower for M&E at the national, state and district levels. However, there was need to build capacity at all these levels, by setting up mentoring relationships with local organizations responsible for M&E. Five JRMs had been held collaboratively by the MOHFW and the DPs, apart from the MTR. However, accountability and follow-up of JRM recommendations has been variable; partly, this was because JRMs generated too many recommendations without allocating specific responsibility for follow-up. It was agreed thereafter that the JRM process would be streamlined, with jointly agreed recommendations and a follow-up plan. Monitoring indicators were reviewed, and some indicators that had proven not to be useful were dropped. A revised and rationalized set of indicators was adopted for the national MIS by the MOHFW, and web-based system for data reporting and presentation was launched. While there were some good practices in the use of the MIS, additional TA was required for successful roll-out. Data from the NFHS-3 was released in 2007, with detailed state reports and disaggregated indicators. The DLHS survey was delayed by a year, leading to a delay in the MTR. Data from the DLHS-3 was released for 24 states in the first phase by July 2008; the remaining came in 2009. The DLHS 4 was never completed in the project's period despite several requests.

Use of Data: Use of data for program management was mixed: overall, the richness of the DLHS dataset was not fully exploited. Some states were using innovative techniques to supplement their routine monitoring systems, while others were merely collecting data for upward reporting and not for shaping priorities and making mid-term corrections. Overall, there is evidence that M&E data were used at the central level: despite the slow start in getting the DLHS off the ground, there was an early focus on achieving results. The close collaboration with DPs, including through more regular interaction with key program managers also helped support this focus. However, with the implementation of the NRHM picking up pace, and the launch of the JSY scheme, there were additional challenges to the M&E function, especially vis a vis the

quality of care. Subsequent to the re-structuring, and in response to the findings of the DLHS-3 survey (2007-08) and the Coverage Evaluation Survey of the UNICEF (2009), MOHFW identified 264 high focus districts with poor health outcomes, and prepared a plan for program management and supportive supervision in these districts and district specific requirements for key inputs and processes. All of these actions speak to better coordination across DPs, and the governments focus on addressing project (and NRHM) bottlenecks and achieving better results, especially in disadvantaged states/districts. Field visits by the ICR team as well as discussions with MOHFW staff show that the quality element as well as data handling and use of data for management at state and district levels still needs strengthening and careful attention.

Overall, implementation of M&E plans continued to be weak throughout, and the release of results from the 2010 DLHS 4 survey have been inordinately delayed thereby making it much harder to document the final project results for this ICR. The absence of an external project evaluation and an end-line survey adds to this weakness. Despite this, the data generated from the previous surveys, as well as from several other related studies were used for re-design and re-orientation, not just of the RCH project over its lifetime, but also the wider NRHM program. RCH II also brought to the NRHM, a relatively new culture of evidence-based programming (especially at the federal level) that was, perhaps one of the greatest strengths and contributions of the project. Further efforts are needed to take this same culture to the state and district level. States with stronger management and technical capacities, such as Karnataka and Tamil Nadu, have been able to benefit from this more than other states such as Madhya Pradesh and Uttar Pradesh.

2.4 Safeguard and Fiduciary Compliance

Procurement: To correct the serious deficiencies in procurement processes encountered under RCH I, an empowered procurement wing was established in MOHFW, and the GAAP was developed to address some deficiencies. While there was reasonable progress on implementing the GAAP, GMP implementation and the required Quality and Quantity Reviews were delayed. The following is a summary of the procurement-related challenges:

- At the central level the procurement of RCH Kits was not only delayed but lack of competition remained an area of concern. Change in procurement approach for kits (other than sub-centre kits) resulted in a better response but the “kitting agent” approach was not tried for kits needed at the sub-center levels.
- There was a felt need for better coordination between RCH division and EPW throughout the implementation period. During the initial years of the Project, the Bank had to mediate between both the divisions as it was unclear who would handle the procurement under the Project. This resulted in enormous delays.
- IEC contracts issued at central level were also not financed due to disagreement on procurement procedure used for these contracts.
- At the decentralized level, lack of compliance with procurement procedures and reluctance of the states to allow the post procurement review (PPR) was noted during initial years, which resulted in DPs deciding not to finance decentralized procurement. This not only resulted in lesser disbursement but also enormous operational difficulties in identifying non-procurement expenditures at decentralized levels. This led to a lost opportunity to strengthen decentralized procurement.

- In some instances, the equipment supplied were found to be non-functional or not in use. Streamlining procurement and logistics management and upgradation of storage facilities were identified as major challenges by some of the states. Some states have experimented with outsourcing of drug storage.
- Governance and Accountability Action Plan (GAAP) for the project envisaged the strengthening of the capacity of the drug regulator and in the interim, use of WHO GMP and audit of GMP certificates were proposed for Bank financed procurement. However, this interim approach is still being used. Conducting GMP audit before awarding contracts resulted in substantial delays in procurement.

Despite above challenges, MOHFW was able to procure Polio Vaccines, two rounds of RCH Kits (one round not financed from the Credit), AD syringes and cold chain equipment. This project also demonstrated usefulness of the procurement agent approach, which MOHFW is planning to continue even for non-Bank financed procurement in some projects like NACP-IV. Strengthening of procurement systems both at central and state levels was successful.

Financial Management and Institutional Strengthening under the project:

Financial management under RCH-II was challenging for various reasons which include (i) significant increases in financial outlays under NRHM coupled with greater decentralization and provision of untied funds to peripheral units; (ii) two parallel pools of funds for RCH-II and NRHM Flexipool for states with certain overlaps in activities and using the same institutional mechanism & common bank accounts; and (iii) a decision by the pooling partners to limit financing to operating costs. Financial management performance in RCH-II had two dimensions: (i) financial management institutional strengthening across the program and (ii) fiduciary, expenditure eligibility and disbursement specific to the pooling partners.

Financial Management Institutional Strengthening: During the course of implementation of RCH-II, MOHFW, under the NRHM umbrella, has retained the focus on progressively improving financial management systems and processes across the program. These include:

- Creation of a Financial Management Group (FMG) within the MOHFW headed by a Director (Finance) with responsibility for financial management systems and oversight over funds (grants) released to states. The development partners (DFID and UNFPA) provided support in strengthening the FMG, both through full time qualified consultants and external FM technical support from Deloitte Touche Tomatsu. (TA from DFID).
- Contracting of a large pool of finance professionals and accountants at state, district and block level.
- Development and periodic update of the financial management manual, which is now applicable to the National Disease Control program as well. This has been supplemented with simple FM handbooks for peripheral service delivery units i.e. CHC/PHC, RKS, VHSC and sub-centers.
- Implementation of e-banking system across the program.
- Roll out of a common IT based accounting system (TALLY)
- Strengthening the process of selection of external auditors with emphasis on quality of the firm.

- Active participation by the FMG in state annual plan reviews and six monthly JRM's using standardized financial management checklists to ensure consistency in review and approach.

However, given the scale of operations under the program (as in any Centrally Sponsored Scheme (CSS) and varying capacities across states, the actual performance and compliance with the processes, especially at the peripheral units has, expectedly, been mixed. This, coupled with the lack of adequate dis-incentives in centrally-sponsored schemes for non compliance by states also contributes to the mixed performance, despite the efforts of the FMG.

Fiduciary, expenditure eligibility and disbursement: non adherence to agreed procurement procedures in the initial years and the decision post DIR to limit pooling partners financing to operating costs, significantly increased the transaction costs, both for the Bank and MOHFW in determining eligible expenditures since the financial reporting formats were not specifically designed to segregate operating costs and the parallel funding under two separate flexipools (RCH and NRHM). Frequent changes in the reporting formats were not feasible given the scale of the operations nor considered appropriate since pooling partners financing was less than 10% of the total program expenditure. The improvement in the quality of auditing brought to light significant internal control issues in selected states and/or districts & peripheral units, leading to adjustments to disbursements in subsequent years. After the initial three years, in consultation with MOHFW, it was agreed to determine eligible expenditure based on acceptable audit reports from the states rather than on the six monthly financial reports. This considerably reduced the administrative costs, but on the contrary delayed the cycle of disbursement by a year.

In 2010, with sustained efforts from the Bank team, both the FM and Procurement functions improved considerably. MOHFW considerably strengthened FM capacity by recruiting finance consultants as well as using the services of a management consultancy firm. Procurement performance also improved with the recruitment of a new procurement agent and completion of first round of procurement and distribution of drug kits.

As a result of these pro-active actions, project ratings for FM and procurement were upgraded from MU to MS in early-2010.

2.5 Post-completion Operation/Next Phase

RCH II objectives and focus have been integrated with GOI's on-going umbrella program, the NRHM, which ensures project sustainability. At both the central and state levels, considerable ownership of the RCH program has been built up, and systems have been put in place for planning and management at central, state and district levels to ensure continuing support, implementation and tracking of RCH inputs and outcomes. Despite the challenging environment in which the project was prepared and implemented, the resulting positive outcomes have led states such as Karnataka and Madhya Pradesh to express interest in follow-on Bank-financed operations in the health sector.

3. Assessment of Outcomes

3.1 Relevance of Objectives, Design and Implementation

Objectives: Expanding the use of essential, high quality RCH services and reducing geographical disparities was and remains an important goal for India and was consistent with CAS priorities. Despite rapid economic growth and remarkable progress on several demographic indicators, the pace of progress in health had been uneven and the quality and use of health services was poor. There had been a slowdown in reductions in infant mortality, with India contributing approximately 25% of the global burden of under-5 child deaths. Similarly, about 25% of global maternal deaths occurred in India, the largest proportion contributed by any single country. Clearly, progress towards RCH goals was not fast enough to achieve the Millennium Development Goals. In addition, important national goals had been articulated in the National Population Policy (2000) to bring the Total Fertility Rate to replacement levels by 2010 and achieve population stabilization by 2045. With the move away from demographic targets post-ICPD 1994 and the 1995 World Bank review of the Family Welfare program, both GOI's Five Year Plan documents and RCH-I placed a greater emphasis on improving service quality as a key strategy towards increasing uptake of RCH services. Finally, addressing regional disparities by focusing on the EAG states was important not only to ensure the achievement of the MDGs, but was also in line with the strategy articulated in the country's Tenth Five Year Plan.

Design: The project design focused on: (i) decentralizing program planning and implementation to the state and district levels, to enhance responsiveness, accountability and ownership. This was in keeping with GOI priorities as reflected in national policy documents; (ii) enhancing access through a range of interventions, including increasing allocations to the EAG states and inducing states to articulate a pro-poor and gender strategy in their annual plans; (iii) strengthening institutions and capacities at national, state and district levels to enhance program management and monitoring; iv) encouraging innovations through provision of flexible funds; and v) strengthening the technical evidence base for RCH interventions. All these efforts were specifically included in response to lessons learned from the preceding RCHI project and were therefore in keeping with the agenda to reform the overall approach of the RCH program. The launch of GOIs flagship national program (the NRHM), ahead of the RCH-II project approval benefitted significantly from and built upon the strengths of the RCH-II technical, FM and procurement preparations. Furthermore, once it became effective, the RCH-II project became synonymous with the NRHM, both in substance, technical underpinnings, reform agenda and donor-support. NRHM remains the government's flagship program and key strategy to-date towards improving health outcomes for the poor in India. Project design and objectives were therefore highly relevant, both at design stage as well as at the end of the project.

Implementation: The introduction of the program approach, bringing together all DPs under the common framework of RCHII preparations was an important step towards enhancing donor coordination. Development of an overall RCH plan and financing it either through the pooling mechanism or outside the pool, allowed all of the potential donors enough flexibility to support the GOIs plan, while still maintaining donor priorities. The emergence of the GOIs flagship NRHM with the highest levels of political commitment ensured ownership of the program at all levels within the country, as well as its sustainability. The project's focus on strengthening management, technical, FM and procurement capacities at national, state and district levels

appropriately moved the implementation responsibilities, accountability and ownership of the project at appropriately decentralized levels.

3.2 Achievement of Project Development Objectives

The following analysis of the project outcome indicators is used as a basis for an overall assessment for the achievement of the PDO. Since the results from the most recent DLHS 4 survey (2010-2011) have not yet been released by GOI, and no external evaluation was planned-for or conducted, these assessments are based on either DLHS 3 data (2007-2008), data from a UNICEF conducted Coverage and Evaluation Survey (CES) in 2009, NFHS data when available, or from monitoring data. Assessing project progress with data from 2007-2008 obviously underestimates results. Therefore, where possible, the ICR team has brought to bear data from all of these other data sources to triangulate results from the DLHS surveys, monitoring reports, field visits, and national demographic and health trends.

Table 1: Progress against PDO targets

PDO Indicators	**Disaggregation**	**Base line (DLHS 2, 2002-04) (%)**	**2011/12**		**Comments/notes and data sources**
			Target (%)	**Achievement at mid-line (DLHS 3, 2007-08 or Coverage Evaluation Survey CES in 2009 (%)**	
% of eligible couples using any modern contraceptive method	Permanent Methods	34	36	35	As per DLHS 3 (2007-08), 19 of 34 states have achieved the target of 52%, of which 4 are from the weakest EAG states. Significant improvements are also documented among SC and ST populations by mid-line.
	Spacing Methods	11	16	12	
	Overall	45	52	47.1	
	SC/ST	SC-43 ST-39	45	SC 49 ST 42	
	EAG States[1]	33	40	4 out of 8 states achieved target by mid-line	
	Lowest Wealth Quintile[2]	NA	NA	35	
% of deliveries conducted by skilled providers	Overall	48	60	76.2%	Latest data from CES 2009.
	SC/ST	35(SC-39.6, ST-28.4)	45	SC-75.7 ST-61.3	Target over-achieved. Progress qualitatively substantiated by field visits by the ICR team in two states MP and Karnataka as well as review of field visit reports from all JRMs.
	EAG States[1]	32	45	65.6	Target surpassed substantially in both SC and ST populations and EAG states.
	Lowest Wealth Quintile[2]	27.5	NA	47.9	No target set but substantial progress so target is assessed as achieved/surpassed.
% of 12-23 months children fully Immunized	Female	44	75	59.9	Latest data from CES 2009. Substantial progress by 2007-8; about

					50% of target achieved by 2009 (CES).
	Male	45	75	61.9	Substantial progress by 2007-8; about 60% of target achieved by 2009 (CES)
	Overall	45	75	54.1	Progress; 12 states achieved target by 2007-08, including two EAG states (DLHS 3).
	SC/ST	SC-41.9 ST-36.5	75	SC-58.9 ST-49.8	Progress noted; about 56% and 35% of target for SC/ST respectively achieved by 2009 (CES).
	EAG States[1]	28	60	61	Substantial progress; Target achieved in two of 8 states in 2007-8; Overall target achieved by 2009 (CES).
	Lowest Wealth Quintile[2]	31.3		47.3	No target but substantive progress from baseline recorded by 2009 CES.
% of mothers and newborns visited within 2 weeks of delivery by a trained worker	Overall	(<10)	40	49.7 (2007-08)	Target substantially over-achieved. MIS data
At least 80% of households with eligible children covered during national & sub-national immunization days in high risk districts			80	98	Target over-achieved and surpassed. India has been certified by WHO as having achieved polio-free status as of Jan 2012; Validated data from National Polio Surveillance Project covering 1% of households

*1. Combined estimate of indicators for **EAG states** are derived using appropriate weights (for example, estimated number of births for IMR, delivery by skilled personnel and immunization and estimated number of eligible couples) for TFR and use of modern methods of contraception*

2. For DLHS, this refers to "Low" category of Standard of living index.

Data triangulation and attribution: Since the RCHII project was designed and implemented as a *contribution* to the overall NRHM and its objectives, and it was implemented in a programmatic mode, and since RCH financial contributions were a small component of the overall GOI contributions for health, it is neither advisable nor feasible to estimate the exact attribution of results to the RCH II project. Instead, consistent with the Paris and Accra harmonization agreements, the focus of this ICR is to see whether/how the RCHII project *contributed* to the observed changes in expanding the use of reproductive and child health services, including addressing disparities across disadvantaged states and population groups. While much of the project progress is based on the DLHS surveys 2 and 3 (conducted in 2002-4and 2007-8 respectively), an effort has been made to triangulate some of these data with additional information from the UNICEF 2009 Coverage Evaluation Survey (CES), and from observations in the field by the ICR team. Even with this effort, the most recent data are from 2009, while the project concluded in March 2012. Therefore, the PDO progress summary table above likely underestimates real progress to-date. Therefore, while the lack of data at project closing is a major limitation (that is noted elsewhere in the ICR), for the purpose of these ratings, based on the fact that project implementation picked-up significantly after mid-term, it is (conservatively) assumed that the trajectory of improvement in project outcomes continues at about the same rate as was documented in the first two years of the project.

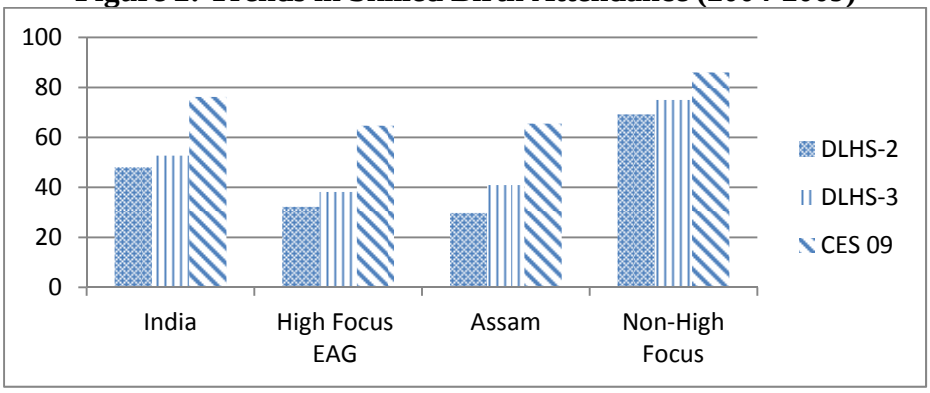
PDO Indicator #1: Percentage of eligible couples using any modern contraceptive method:
19 of 34 states had achieved the target in 2007-08, of which 4 are from the weakest EAG states. Significant improvements are also documented among SC and ST populations by mid-line. In addition to the observed trends in increasing use of modern contraceptives, female sterilization rates declined from 77% at baseline (DLHS-2) to 74.3% at midline (DLHS-3). Male sterilization

rates showed only a marginal increase from 0.9 % to 1.0% during the same period. Use of spacing methods increased from 10.2% to 12.0%. Major contribution to spacing comes from use of condoms which showed an increase from 47.1 during DLHS-2 to 49.2% for DLHS-3. Use of oral contraceptives increased only marginally (35% from 34.3%) the while IUD use declined from 18.6% to 15.8%. Only 9.2% couples used spacing for more than six months. Among the EAG states this varied from 1.9% for Bihar to 12.6% for Uttarakhand. Overall, the assessment is that this objective was likely achieved by March 2012.

Rating on PDO indicator # 1: Satisfactory.

PDO Indicator #2: Percentage of deliveries conducted by skilled providers (doctors/ANMs/Nurses): The results of Coverage Evaluation Survey (CES-2009) indicate an overall improvement from a baseline of 48% (2004-05) to 76.2% in 2009. 23 out of 29 States (6 Union Territories excluded) have achieved the overall end-line target of 60%.

Figure 2: Trends in Skilled Birth Attendance (2004-2009)

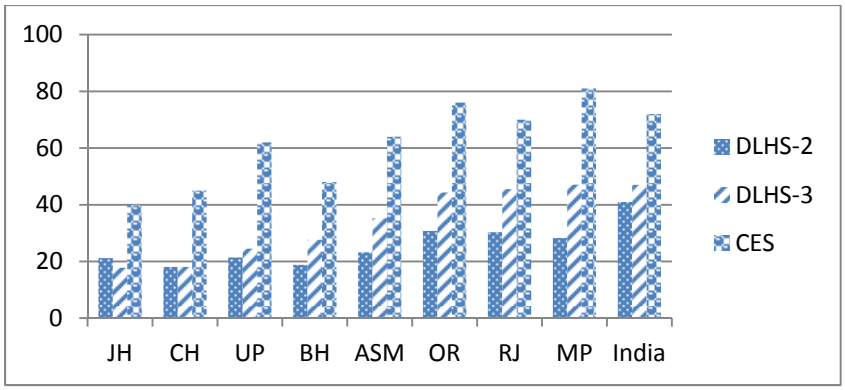


Disadvantaged groups such as scheduled castes, scheduled tribes and lowest wealth quintile have also registered an improvement over base line: skilled birth attendance has almost doubled for scheduled caste groups between 2002-04 and 2009; and slightly better than doubled for scheduled tribes and those in the lowest wealth quintile during the same period (although there was a small decline for the latter group during the DLHS-3). For the 8 EAG States there is a combined improvement from the baseline of 32% to 65.5% against the end line target of 45% for EAG States. Four EAG states have even achieved the national target of 60%.

The 2005-6 National Family Health Survey (NFHS) showed that 72 percent of women who did not have an institutional delivery said they did not deliver their last child in a health facility because it was not necessary. Twenty-six percent said it was because it cost too much and eleven percent said it was too far/no transport. Recognizing these constraints, several innovations were developed under the project to off-set travel costs and provide incentives through the introduction of the *Janani Suraksha Yojana* (JSY), and to introduce on-call free ambulances to bring mothers to hospitals for safe delivery. As a result of many of these innovations, data show large increases in absolute numbers of institutional deliveries: State-level data shows significant improvement in the number of deliveries at the public sector health institutions. Institutional deliveries increased by 55.4% during the seven year period from 10.8 million in 2005-06 to 16.8 million in 2009-10. Institutional deliveries more than doubled overall in the EAG states; and

while all EAG states have shown improvement, in Jharkhand, Chhattisgarh and Bihar, institutional deliveries have quadrupled, tripled and doubled respectively. The North Eastern States have also shown increase of more than 100%. In Assam the increase has been nearly threefold. Nagaland and Sikkim have however shown very small declines. Data from the DLHS 2 and 3 and the CES show similar trends, as seen below. While institutional deliveries in UP and Rajasthan are approaching the national average, both Orissa and Madhya Pradesh have outstripped the average by between 5-10%.

Figure 3: Institutional Deliveries in EAG States



Overall, the ICR assessment is that this objective was likely achieved and surpassed, including in the EAG states and SC/ST populations by March 2012.

Rating on PDO indicator # 2: Highly satisfactory.

PDO Indicator #3: % of 12-23 month old children fully immunized: 12 out of 34 states were reported to have achieved the end-line target before mid-term in 2007-08. Of the eight weak EAG states two had achieved the target of 60% coverage by 2007-8. According to the UNICEF CES survey, the coverage rates for these states were 61% in 2009, against a target of 60%.

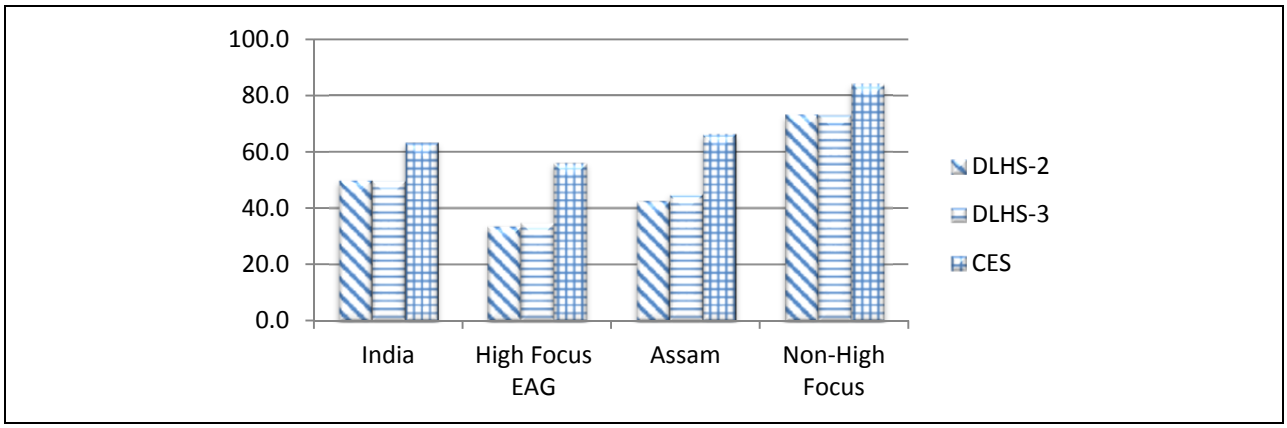
Overall, the assessment is that the indicator target was likely achieved.

Rating on PDO indicator # 3: Moderately satisfactory.

PDO Indicator #4: % of mothers and newborns visited within 2 weeks of delivery by a trained worker: Data on this indicator was not tracked, but the coverage data from DLHS-3 (2007-08) is 49.7%, against a target of 40%. This ICR, also looked at a related indicator on ante-natal care (ANC) which was tracked through the joint review missions and the DLHS surveys. Access to care during pregnancy has gone up significantly during the project period. Across the board, women making at least one ANC visit has improved from about 73% in 2002-04 to 87% in 2009-10, while those making 3+ ANC visits (which is the gold standard for health care) has increased from 50% to 63.3% during the same period. All EAG states have shown improvements with Bihar going up from 37.9% to 84.3% for at least one ANC visit and from 19.3% to 33.8% for 3+ visits. Uttarakhand, MP and Orissa too have shown marked improvement in coverage for

3+ ANC visits. All of these are indicative of improved uptake of reproductive and child health services.

Figure 4: Percentage Trends in Ante Natal Care (3+ ANC visits/woman) (data from DLHS 2 (2004/5), DLHS 3 (2007/8), and CES 2009)



Overall, the ICR team's assessment is that this indicator was surpassed.

Rating on PDO indicator # 4: Highly satisfactory

PDO Indicator #5: At least 80% of households with eligible children covered during national & sub-national immunization days in high risk districts: Although it is implicit (and the team responsible understood the indicator this way) that this indicator (which replaced the original PAD indicator of "polio-free status achieved) refers to polio vaccination coverage, the indicator does not state that explicitly. This revised indicator was specifically used by the National Polio Surveillance Project to track polio immunization in the states of Bihar and UP, where all the high risk polio districts in the country were located, so the change in the indicator was both technically and strategically correct. The target was reduced during restructuring in 2010 from the original PAD target to make it less ambitious as global evidence indicated that polio eradication was proving difficult to predict despite strong program implementation. Hence, indicators similar to a more recent project focused on coverage of high risk areas was considered more appropriate. In fact, the ambitious original target was achieved in January 2012. This was a historic achievement, not just for India, but for the entire global health community. India has been certified polio-free by WHO, based on data from the national polio surveillance project.

Overall, the ICR team's assessment is that this objective was fully achieved by March 2012.

Rating on PDO indicator # 5: Highly satisfactory.

Overall trends in maternal and child health outcomes during the project period:
Though there are no updated data on PDO indicators 1-4, overall progress on maternal and child health outcomes (which are further down the results chain) has been very positive, and many improvements have been documented in EAG states, as well as among the SC and ST populations that represent the poorest and most under-served populations in the country. This progress is especially substantiated by documented improvements in two important reproductive

and child health outcome indicators -- Maternal Mortality Ratio (MMR) and Infant Mortality Rate (IMR). Data from the National Sample Registration Surveys indicates that the MMR for the country has declined from 301 per 100,000 live births in 2001-03 to 212 per 100,000 live births in 2007-09:[4] this represents an average annual decline for India as a whole of about 4.22% per year from 2002-08. The data also shows interesting inter-regional differences: While the EAG states and the North Eastern state of Assam are still well above the national average in maternal mortality, they have had a faster rate of annual decline particularly in the four years between 2004-08 (a decline of 4.47% as compared to 4.13% nation-wide).

Table 2: Trends in Maternal Mortality Rates 2001-03 to 2007-09

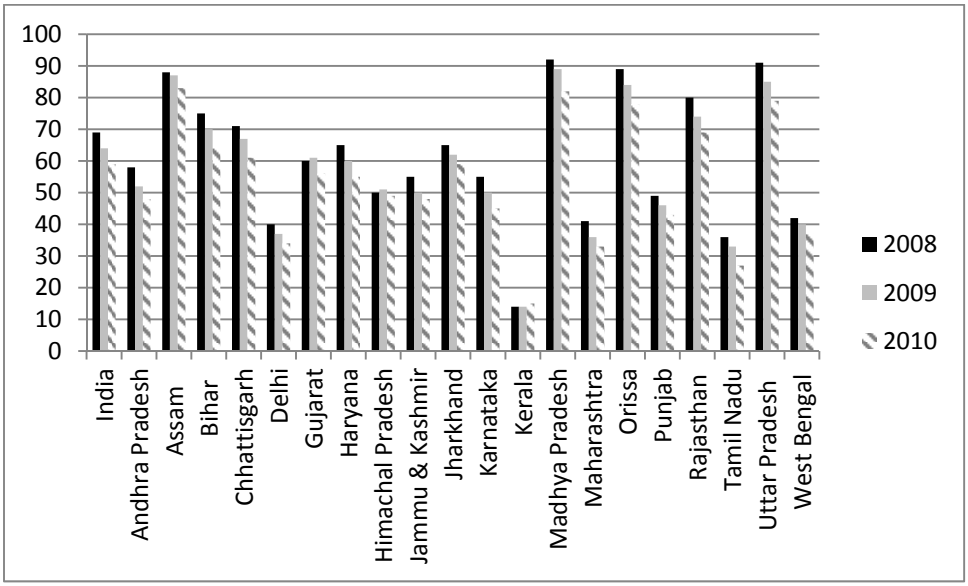
India/ States	2001-03	2004-06	2007-09	Decline 2002 to 08 (7 yrs)		Decline 2004 to 08 (4 yrs)	
				Total	% /Yr	Total	%/Yr
India	301	254	212	89	4.22	42	4.13
EAG States & Assam	438	375	308	130	4.24	67	4.47
Southern States	173	149	127	46	3.79	22	3.69
Others	199	174	149	50	3.58	26	3.74

The MDG goal for child mortality in India is to achieve an IMR below 30 per 1,000 live births by 2015. During the period 2005-2010, IMR in India declined from an average of 58 in 2005 to 47 in 2010, an overall decline of 18.96% with an average annual decline of 3.16%, although most states will not achieve the MDG goal of <30 per 1,000 live births. IMR and Neonatal Mortality Rates (NMR) for India were 47 and 33 per 1,000 live births respectively in 2010. In comparison, the average IMR and NMR for the EAG states and the north Eastern state of Assam are 54 and 37 per 1,000 live births respectively. Within the EAG states, the disparities are quite wide: from an IMR of 42 in Jharkhand to 62 in Madhya Pradesh; and an NMR of 31 in Bihar to 44 in Madhya Pradesh.

Under-five mortality (U5MR) has stayed about the same from 60 per 1,000 live births in 2008 to 59 per 1,000 live births in 2010.[5]With an average of 71, the EAG states and the North-eastern state of Assam perform poorly compared to the national average; and U5MR rates range from 59 in Jharkhand to 83 in Assam. However, some states, such as Bihar and Orissa have registered impressive improvements, reducing under-five mortality rates by 12 and 11 points respectively between 2008 and 2010. Under-five mortality has declined from 76 to 66 per 1,000 live births in rural areas and 43 to 38 per 1,000 live births in urban areas. Apart from UP, where U5MR declined by only 3 points between 2008-10, all other EAG states and Assam registered a decline of 8-9 points per 1,000 live births. Most recent data for 2012 are not available for any of the above indicators.

[4] Registrar General of India: Report of the Sample Registration System on MMR; 2009.
[5] Registrar General of India; Sample Registration Survey, 2010.

Figure 5: Trends in Under-five mortality across states 2008-2010
(Data Source: Registrar General of India; Sample Registration Survey, 2010)



These unprecedented and impressive overall declines in maternal and child mortality over the last decade add credence to the conclusion that the RCH II project contributed to these improvements by increasing access to services under the umbrella of the NRHM. Overall, it is useful to note that many of the RCH II project targets were achieved fairly early-on in the project cycle, suggesting that these targets could have been set higher.

3.3 Efficiency

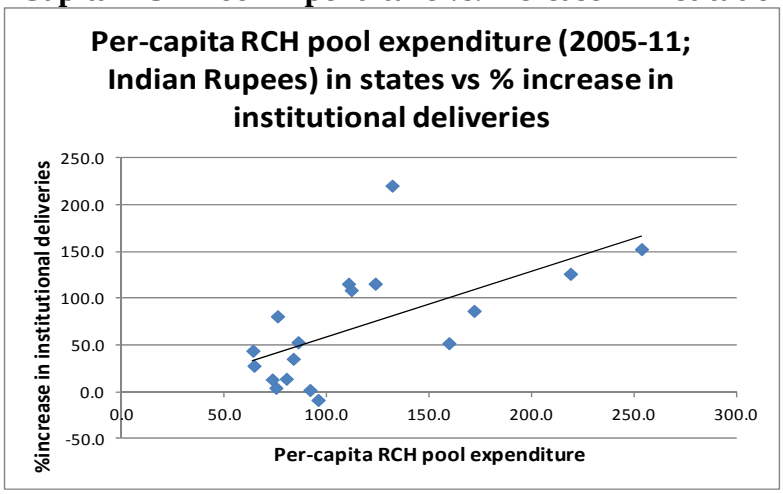
As already noted, the project was highly relevant for the programming and policy context in India, not just as an investment credit, but as a policy instrument that leveraged much larger resources from GOI for scaling-up high-impact interventions. RCH II was designed at a crucial time in India's history -- following a period of sustained economic growth which, unfortunately was not accompanied by concomitant improvements in health outcomes. India remained a laggard on many health indicators –from polio, to maternal and child health. With strong political support from the highest levels, the government, therefore, launched rather quickly a high-profile, national flagship program, the NRHM which benefitted significantly from RCH preparations. NRHM's primary objective was to step up public health spending from 1% of GDP in 2004-05 to 2 - 3% of GDP by 2011-12. The RCH II project was influential in shaping GOI policies and the technical underpinnings of NRHM. GOI expenditures for health did in fact increase from US$2.1billion in 2005-06 to US$6.9 billion in 2012-13 (20% per annum in nominal terms), and nearly 70% of this was allocated for RCH-related services, and as many of the innovations and strategies piloted under RCH II were scaled-up through NRHM, the boundaries between RCH II and NRHM blurred further.

Between 2005-06 and 2011-12, 63% of total central health spending was on NRHM and nearly 70% of total NRHM funds were for RCH-related activities. "Pooled" RCH financing by external donors, including the Bank financing, went into RCH flexi-pool that accounted for about 19% of

total NRHM allocations. A large percentage of these funds were pro-actively targeted to the EAG states.

RCH II project preparation had carefully selected high-impact, evidence-based interventions to be included as part of the intervention package. DALY assessments show that these interventions are cost-effective, with a range of $25-1000 per DALY. Further, there is a strong positive correlation (0.614)[6] between per-capita RCH flexi-pool expenditures (primarily through the JSY cash-incentive scheme) and increase in the rate of institutional deliveries across states between 2005-06 and 2010-11 (see Figure 6 below) suggesting that the RCH-flexi-pool was indeed the major force behind the promotion of institutional deliveries.

Figure 6: Per Capita RCH Pool Expenditure vs. increase in Institutional deliveries



However, for IMR, the correlation (not causality) between per capita NRHM expenditures (70% of which were for RCH activities) and IMR rates in states is low. This could signify many potential trends -- that RCH/NRHM resources are targeted to the worst-off states (which suggest good allocative efficiency), and/or that improving health outcomes such as IMR depend on inputs from several sectors, including, but not limited to the health sector.

Of the cumulative expenditures from 2005-06 to 2010-11 on polio, a little more than 50% went to Bihar and Uttar Pradesh – the two states from where polio cases were still being reported. Project restructuring in May 2010 reallocated additional funds to finance polio operating costs that was disbursed on the basis of number of children immunized at standard costs.

Overall, the project focused on high-impact, lower-cost interventions, and targeted the EAG states and the SC/ST populations. This suggests high allocative efficiencies across states and population groups.

[6] NFHS-3 data were used for estimating institutional deliveries in 2005-06 and MIS and 2011 census data were used for institutional delivery rates for 2010-11.

3.4 Justification of Overall Outcome Rating

The following rationale is used for arriving at the overall outcome rating:

- project relevance was and remains high;
- allocative efficiencies were high and budgets were progressively targeted to pro-poor and gender-sensitive investments in weaker states;
- most of the PDO objectives and supporting indicators, including addressing inequities, were achieved, and several were surpassed;
- the credit was fully disbursed at closing;
- there were several unintended positive outcomes (see section 3.5 below); and
- although significantly better than many previous operations in India, overall, M&E was weak.

The significance of the synergies achieved between RCH II and the GOI's umbrella program for improvement of RCH indicators – the NRHM – cannot be over-emphasized. The coordinated program has been crucial to bringing about the gains in RCH outcomes. In addition to bringing significant additional funding, the synergies between the RCH II project and the NRHM program helped to drive major policy and programmatic shifts, enhanced supply-side interventions through provision of infrastructure, human resources and other inputs, and emphasized demand-side interventions such as the JSY (cash-incentives) and a community outreach worker (ASHA) to encourage women to deliveries in health facilities[7], while also encouraging and facilitating donor coordination. In addition, the focus on checklists for standards of care for various levels, upgraded public sector hospitals, and partnerships with the private sector, put into place mechanisms for providing emergency transport for deliveries in health facilities and strengthened program management systems. Perhaps one of the other greatest successes of RCH II was the innovations in service delivery that it fostered. A full list of innovations is not feasible here, but several innovations such as the JSY and emergency transport facilitation emerged from this crucible.

Based on the above, the overall outcome for the project is rated as Moderately Satisfactory. Had the M&E component been stronger, and had the ICR team received the results from the last DLHS 4 survey or a third-party external evaluation to further substantiate the achievement of the project targets at end-line, the project could have qualified for a satisfactory rating. Without these data, the ICR team hesitates to rate the overall outcome as satisfactory.

Overall Outcome Rating: Moderately Satisfactory

3.5 Overarching Themes, Other Outcomes and Impacts

(a) Poverty Impacts, Gender Aspects, and Social Development

Addressing inequities was an important objective of the project. To this end, several intervention strategies were adopted to address this issue including: (i) increasing the number of rural health

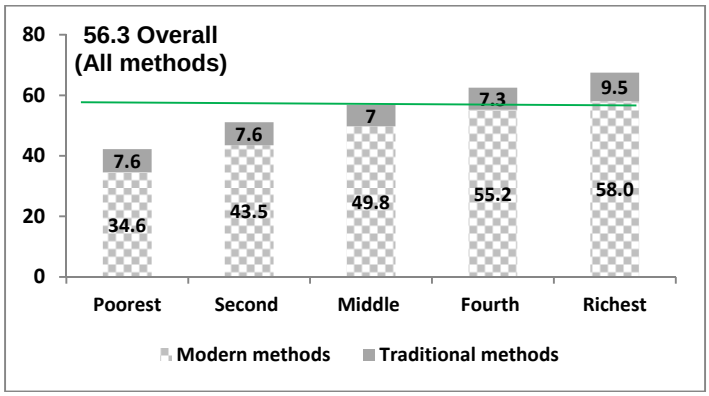
[7] Vikram Rajan, VK Manchanda and S Nagarajan. Quality of Obstetric Care in India: will we 'deliver' on time? Public Health Foundation of India;

facilities and providers (additional ANMs, nurses and recruiting more than 600,000 new community health workers (ASHAs[8]) who were paid for services delivered instead of monthly salaries, increased facilities for emergency obstetric care and blood bank/storage units); (ii) enabling available providers to provide a wide range of services (through training of ANMs and ASHAs in integrated management of childhood illnesses, and anesthesia training for graduate doctors); (iii) helping vulnerable groups access health care (with the help of the ASHAs); and strengthening demand side financing through the JSY scheme. In addition, the focus on results (vs. inputs) was a major paradigm shift for health policy in India.

An evaluation conducted as part of the MTR found that some of these interventions had worked well. These included the accreditation and equipping of sub-centers for providing 24x7 RCH services; launching of mobile health clinics in tribal blocks; and introducing adolescent reproductive and sexual health programs. On the other hand, some persistent challenges include: analysis and use of gender disaggregated data for planning and priority setting; accountabilities for planning and following-up on equity issues; and lack of effective trainers for enhancing sensitivity to gender and equity issues. The prioritization of vulnerable groups varied significantly across states, and the review recommended that states adopt a methodology for allocating funds/tracking expenditures based on the proportion of the population that belonged to vulnerable groups. It also suggested that a performance bonus be given to states that performed particularly well. Furthermore, data showed the following trends:

- *Poverty impacts*. The effect of poverty on RCH outcomes is clear: While 50 percent of the poorest 20-24 years old women have had a child before reaching 18, only 9 percent of their richer counterparts did. The rich-poor gap in early childbearing has increased across cohorts. There are socioeconomic differences in the use of modern contraception among women as well: modern contraceptive use is 58 percent among women in the wealthiest quintile and 35 percent among those in the poorest quintile. Clearly, more needs to be done to address this equity gap.

Figure 7: Percent use of contraceptives among married women by wealth quintile



Source: DHS Final Report, India 2005-06

[8] The term "*Asha*" in Hindi means hope.

- *Socio-cultural barriers to health seeking behavior:* Demand for services is affected by socio-cultural barriers, which need to be addressed through effective strategies. The ASHA is an important catalyst introduced under the JSY; ICR visit showed that where ASHA's had undergone training, their skills were good. In states/districts where training or monitoring was weak, their skills were less impressive. In addition, effective use of media and other forms of communication are required to change community perceptions about the importance of delivery with skilled health personnel. While communications were in general stepped-up under RCH II and NRHM and most facilities visited by the ICR team had the usual posters and wall paintings, and even new flat-screen TVs and video facilities, there is still much scope for more strategic and better targeted high-quality health communications.
- *Gender:* A specific gender review was conducted for the midterm review of the programme which focused not just on gender equity within health services use, but also the issue of sex selective abortion, and implementation of the Indian PCPNDT Act. The review (and previous JRMs) outlined a number of recommendations on improving states approach to sex selective abortion, many of which states have begun to implement.
- *Some mis-placed priorities*? Access to safe water seems to be a continuing shortfall in many heath facilities. The ICR team visited several facilities in MP and Karnataka that were fully equipped with flat-screen TVs and other equipment, but had no water in the taps. In many cases this was because of a lack of electricity and generators had not been provided. In other cases, however, the problems were simple water-point issues that had not been resolved despite availability of flex-funds. Provision of safe deliveries and basic RCH services in the absence of running water, is, needless to say, a huge challenge.

(b) Institutional Change/Strengthening

Under RCH I, MOHFW and donors made extensive use of consultants to augment capacity at the national, state and district levels. In addition, external agencies had been contracted for procurement, training, IEC, community surveys and technical support. There was a lack of coordination between and among these consultants, and technical assistance was limited to the center. The RCH II program, therefore, addressed these constraints by: (i) strategically using existing consultants (supported by some DPs) for the entire sector; (ii) creating a core group of state facilitators to strengthen program implementation at the state level; (iii) clearly defining the roles and responsibilities of the state and district management units; (iv) establishing an Empowered Procurement Wing to coordinate and provide technical assistance to the states to improve procurement and logistics; and (vi) hiring agencies to independently monitor the performance of non-EAG states. The primary focus of this strategic shift was to strengthen institutional capacities for programmatic sustainability, as follows.

Central level: A National Program Coordination Committee was set up at the MOHFW under the leadership of the Secretary, Health and Family Welfare, and supported by a team of technical and finance staff to provide policy steer, particularly to enhance system efficiency and to enhance coverage, quality and equity of services. This team was responsible for developing the national program, facilitating and monitoring state level planning, establishing technical standards, providing financial and other oversight, procurement and M&E. State facilitators were also appointed for each large EAG state and sub-groups of other states.

State level: The State Health Mission (under the NRHM) was to provide oversight for the RCH program at the state level, with technical and program management functions being undertaken by the RCH State Program Units. States were to be responsible for providing an enabling policy framework for PPP and overseeing all aspects of planning and implementation. States would also be responsible for assessing the implication of NRHM for the RCH program and put in place necessary coordination mechanism.

District level and below: The District Health Mission (under the NRHM) was to provide oversight for the RCH program under the leadership of the Chairman, *Zilla Panchayat*/District Collector. The District Health Action Plans (DHAPs) were to be developed at this level.

Capacity Building: Capacity building was an area for intensive engagement. DPs provided TA to weaker states on the basis of an agreed modality. In addition, RCH II invested in establishment of a National Health Resource center (NSHRC) to provide technical support to MOHFW and needs-based logistic support to the states for improved governance and management capacities. The NSHRC was also designed to provide coordinated and sustained technical assistance, with flexible systems to be responsive to the demands of states and districts. Overall, this objective was achieved to quite an extent, albeit much more is needed, especially at decentralized levels.

Effectiveness of Implementation Arrangements:
Political commitment to the RCH program at the central level was high, with strong leadership at the national level and growing enthusiasm shown by a number of states: this was reflected in the increased momentum of project implementation from early-2008. Despite this, there were many issues relating to program management and institutional strengthening. Additional areas for further action include strengthening of training, particularly skill-based training; improving quality assurance of RCH services; and ensuring the timely availability of survey data to measure end-line program outcomes.

(c) Other Unintended Outcomes and Impacts (positive or negative)

The RCH II project was designed to complement the GOI's umbrella program for improvement of RCH indicators – the NRHM. However, the synergies achieved between the two far surpassed all expectations, and hence these – cannot be over-emphasized. The coordination and convergence between the two has been crucial to bringing about the observed improvements in maternal and child health outcomes in India. These synergies helped to drive major policy and programmatic shifts, enhanced supply-side interventions through provision of infrastructure, human resources and other inputs, and emphasized demand-side interventions, while also significantly facilitating donor coordination. Furthermore, the partnerships with the private sector and the innovations in service delivery that it fostered, albeit planned to some extent, surpassed expectations and were perhaps one of the other greatest successes of RCH II. The goals of the NRHM were almost completely synchronized with RCH II – the focus on decentralization, attention to technical rigor, governance and accountability, strengthening fiduciary and procurement systems and managerial capacities, especially at decentralized levels. While some of these may have been envisaged at design phase, many were not.

4. Assessment of Risk to Development Outcome

Given that the RCH II strategies and inputs have been completely synchronized with the NRHM program, the continuing high level of political and financial commitment to health in general and to NRHM in particular by GOI and partners, and the sustained improvements in health outcomes (both maternal and child health outcomes) observed over the last half decade, the risk to development outcome is low. GOI is highly committed to the RCH agenda and is likely to continue to support it, with or without World Bank support. Capacities have been built at central and decentralised levels for better fiduciary management and procurement; programmatic and M&E capacities at state levels, albeit still far from ideal, are significantly better than in the past. All of this provides a sound basis for sustaining program momentum and results. However, the kind of technical rigor and focus on results that RCH II brought to the NRHM program will continue to be critical to achieving results and sustaining them in the future. Furthermore, the recent slow-down in the economy in India may strain national budgets, and allocations for social sectors like health and education may be at-risk.

Risk to development outcome Rating: Low

5. Assessment of Bank and Borrower Performance

5.1 Bank Performance

(a) Bank Performance in Ensuring Quality at Entry

The Bank task team prepared a high-quality project that was consistent with national priorities, remains relevant to-date, that was consistent with CAS priorities, and that was based on solid epidemiological evidence and programming lessons from RCH I. This was the first project in India as a follow-up to ICPD II, that significantly influenced national policies, brought donors together around a common agenda, and helped build implementation capacities at all levels. The project was affected by the DIR investigations in the health sector, which led to significant strengthening of the design of the fiduciary and procurement arrangements, and the implementation of the GAAP. Significant economic and sector work on fiduciary, governance and accountability issues under-pinned the approval of this project which was kept in-limbo for nearly a year, while larger governance and accountability issues in health in India were being resolved. A QER was conducted and most of the QER recommendations were addressed in the design. However, as noted earlier, preparation could have benefitted from a more rigorous results framework, and from an external evaluation, especially in view of the focus on results.

Overall quality at entry: Moderately Satisfactory

(b) Quality of Supervision

Supervision quality benefitted from team continuity. Although the TTL changed after project approval, continuity and institutional memory was maintained with support from a senior co-TTL until 2009, who also mentored the new TTL. The most challenging task for the supervision team was re-establishing dialogue with the GOI and DPs, focusing on the technical and programmatic issues, while also keeping due attention on the Governance and Accountability (GAAC) agenda. The supervision team's adeptness and proactive efforts to re-engage and to build a very cohesive, constructive and functional DP group is especially noteworthy, as is the

implementation support on programme management and financial management within the challenging programming environment. The constant pressure to the FMG to get information up from the states throughout the project period helped improve the flow of financial information and to underpin the role of FMG in driving financial management improvements. The team carried out an in-depth assessment at MTR with pooling and non-pooling partners, and concluded that the project needed to be restructured. The results frameworks were revised during supervision, joint review missions were instituted with other donors and GOI, thereby also strengthening donor coordination. This was a herculean task, especially when additional NRHM funding dwarfed IDA financial contributions for RCH II. Project disbursement was indeed much slower than anticipated in the first few years, but these delays were to be anticipated in view of the DIR recommendation, as well as the sudden in-flux of large amounts of NRHM resources, and weak procurement and implementation capacities at decentralized levels. Follow-on fiduciary actions were put in-place within the first two years, and the fact that disbursement picked-up after that speaks to the team's commitment, skills and understanding of the political economy and programming environment. Given that many of these issues were identified in 2008-09, the team could theoretically have proposed earlier restructuring of the project, but given the challenges of re-engagement in light of the DIR, the delay in restructuring was both prudent and perfectly timed.

Overall quality of supervision: Satisfactory

(c) Justification of Rating for Overall Bank Performance

Based on the harmonized criteria for ICR guidelines (updated 2011), overall Bank performance, which includes project preparation, supervision, evaluation and the Bank's handling of the DIR, is rated as moderately satisfactory. Without the challenges posed by the DIR and with a timely end-line evaluation, a Satisfactory rating would have been justified.

Overall Bank performance: Moderately Satisfactory

5.2 Borrower Performance

(a) Government Performance

Building on the preparatory work for RCH II, the government of India launched its flagship National Rural Health Mission implemented by MOHFW. While this deflected some attention from the project itself since it pre-empted the launch of RCH II, it showed the government's commitment to the RCH agenda. The synergies between the RCH II project and the NRHM program helped to drive major policy and programmatic shifts, enhanced supply-side interventions through provision of infrastructure, human resources and other inputs, and institutionalized innovative demand-side interventions such as the JSY (cash-incentives) and a new army of community outreach workers (ASHAs). In addition to the strong technical and governance focus, the NRHM came with an explicit health financing goal to step up public health spending from 1% of GDP in 2004-05 to 2 - 3% of GDP by 2011-12. This also meant that the share of central government financing for public health rose to nearly 35%, the balance being contributed by states from their own budgets. This financing allowed the central MOHFW to play a much more strategic role in guiding policy and instituting reforms than would have been feasible otherwise in decentralized India. Within this envelope, 70% of the budgets were allocated to RCH-related services. While overall and in the longer-run this was a very strategic

move that rapidly tripled public-health spending in India and greatly enhanced the enabling environment for health in general and RCH issues in particular, it led to some confusion about the programmatic and fiduciary boundaries between the RCH II project and NRHM as evidenced by initial implementation delays at state and district levels. This ambition was however challenged by the weak fiduciary and program management capacities at these decentralized levels and it took some time for these capacities to be built. This led to delays in project implementation and significant challenges to governance and accountability that needed time to be addressed.

Overall government performance: Moderately Satisfactory

(b) Implementing Agency or Agencies Performance

MOHFW invested significant technical and management capacities during the design and implementation phase. As was to be expected, building these capacities was a gradual process, especially at state and district levels. The first few rounds of the process of development of state level PIPs were challenging. The quality of PIPs was strengthened in subsequent years; however, building sustainable and high-quality implementation capacities at district and state levels still remains a challenge, especially in some of the EAG states. MOHFW did well in instituting Joint Review Missions (JRMs) but continues to experience some ongoing challenges with conducting DLHS surveys and timely release of these data for evaluation.

Overall implementing agency performance: Moderately Satisfactory

(c) Justification of Rating for Overall Borrower Performance

GOI has made health a high and sustained priority for the country and has invested significant national resources -- both financial and human -- to support the RCH agenda at national and decentralized levels. The borrower was strategic in building on RCH II project preparations to develop the flagship NRHM, thereby minimizing competing priorities, enhancing allocative efficiencies by targeting weaker EAG states and inequities therein, and ensuring technical rigor and efficiency. Despite challenges to governance and accountability, and weak management and implementation capacities at the start of the project, implementation picked up after initial delays, and infrastructure, human-resources and supply-chain management of drugs was significantly strengthened. These start-up delays are not unusual for large projects of the scale of RCH II, especially in a decentralized setting with variable capacities and contexts. Almost all the PDO target outcomes were achieved before the end of the project, and several were surpassed. This is no small achievement for any country, especially one with the scale and diversity that defines India. Furthermore, even after the closing of the Bank project, the government's program, the NRHM remains firmly in place and working towards the RCH objectives. The greatest weakness remains the delay in release of the DLHS 4 survey data that would have provided more definitive information on project achievements until 2010, close to the end line of the project. Greater attention to M&E would have significantly strengthened the project ratings.

Overall borrower performance: Moderately Satisfactory

6. Lessons Learned

Many technical, programmatic and strategic lessons learned have been recorded both in the various review documents of the MOHFW and Bank/DPs, as well as in a comprehensive review

of the reproductive health, and child health and nutrition program in India published in the Lancet.[9] A few key lessons are as follows:

- *Governance*: A strong framework and leadership for governance in the health sector is necessary for achieving health goals. The project demonstrated that despite many challenges it is possible to design and implement a successful project despite the frequent changes in central-level leadership which are not uncommon in India. While the project benefitted significantly from the launch of the centrally sponsored NRHM and the strong central government commitment and policy directions, it was not entirely dependent on the center and much of the implementation responsibilities lay at the decentralized levels. The project was resilient to some leadership changes at state level as well –for example over the last four years, after the launch of the NRHM, Uttar Pradesh, Uttarakhand, Chhattisgarh, Bihar and Rajasthan have had seven, six, five, four and four secretaries of health respectively. Strong technical leadership was key in building this resilience.

- *Detailed Implementation Review (DIR):* RCH II was the first project to be approved by the World Bank's board after the launch of the DIR. The DIR, and the mode in which it was implemented, posed significant challenges for the project and delayed project approval and implementation. Perhaps one of the first lessons in this context is the need to re-think how such governance challenges could be managed differently in the future, without impacting project outcomes. Despite these challenges, this process led to strengthening of fiduciary and procurement procedures, and institutionalization of the Governance and Accountability Action Plan (GAAP) that also offers significant positive lessons and way-forward for supervision of future projects. However, task teams need to find a way to ensure that procurement and fiduciary discussions, while essential, do not crowd out a focus on technical issues.

- *Technical leadership and capacities*: Building technical excellence and capacities within the country is critical, especially in the Indian context. While MOHFW is building this capacity gradually, (as especially evident in MOHFW leadership of the Joint Review Missions) there is still a large reliance on international donors and agencies to provide this technical advice and inputs. In the longer term, national and state level technical experts need to be in-position at central and state levels to develop and support implementation of national guidelines and strategies. In this context, further focus on program management of district-level capacities is key, since the district is the basic level of planning and implementation in India. A related key lesson from RCH II is that when health investments are focused on evidence-based strategies, impressive results can be achieved, even in challenging environments.

- *Gender:* RCH II showed that it is possible to build-in successful gender elements in to large reproductive health projects, so long as these elements are tailored to the country and cultural contexts. The case of RCH addressing sex-selective abortions is a case in point. Often these sorts of interventions and discussions happen during supervision visits –as was the case herein—where gender issues were flagged in several JRMs.

[9] Paul VK et al. Reproductive Health, and Child Health and Nutrition in India: Meeting the Challenge. India: Towards Universal Health Coverage 2; The Lancet; January 2011.

- *Quality enhancement:* One key learning from the project was that demand-side interventions (such as JSY) are important and possibly necessary, but not sufficient conditions for quality enhancement. Going forward, additional efforts are needed to strengthen the quality of the RCH services, in addition to those already underway (such as accreditation, third party review, quality improvements at clinic level, team based training and reviews, strengthened skill trainings such as SBA and IMNCI, etc).

- *Infrastructure and Human resources for health:* While major progress has been made in improving critical health infrastructure (65% CHCs had operating theaters and 70% hospitals had blood banks by 2007), significant gaps remain, especially in basic infrastructure such as provision of safe and continuous water supplies in health facilities. Similarly, albeit human resources have increased considerably, many challenges remain, including especially accountability and doctor absenteeism (of four doctors posted at a peri-urban CHC with a patient load of 25 per day, visited by the ICR team), not one was present during regular CHC opening hours. Training of doctors in anesthesia and pediatrics (short course) and other such strategies still need to be strengthened; and there needs to be follow up to ensure that doctors with this training are actually deployed so they use their newly acquired skills. The need for continued focus on capacity strengthening, including at district levels, is a key lesson for the future.

- *Financing model to enabling reforms and innovations*: Despite the fact that health is a state subject in decentralized India, the financing model followed by RCH II and NRHM, whereby federal budget allocations were tied to specific reforms and strengthening state and district-level capacities, greatly enabled wide-spread policy reforms. Further, the provision of some flexible funds went a long way in enabling innovations at state and district levels. The project enabled countless innovations in service delivery models, especially at state and district-levels. This is one of the key success factors for the project, and it would not have been possible without the flexible funds at decentralized levels. Future projects may benefit from a similar approach.

- *Monitoring and Evaluation:* Using reliable and timely sources of data as the basis for monitoring a program enhances the credibility of reporting. This is a more expensive strategy, since conducting a national survey such as the NFHS or the DLHS costs money; but the pay-off is significant. The data generated are credible and allow for national level comparisons and analyses since the methodology is uniform across geographies. However, unnecessary delays in release of data detract from both the credibility of the data, and the ability to make mid-course corrections. Rigorous external program evaluations, with special attention to the weaker EAG states, could add significant value to RCH II and NRHM. This remains among the greatest weaknesses of the otherwise successful RCH II project and the NRHM program that needs to be addressed in future projects.

- *Targets:* Since most of the program targets were achieved well before the end of the project and many were surpassed, the question remains whether the targets could have been set higher and whether these could have been adjusted upwards at the time of restructuring? However, at the time of restructuring, data from DLHS 3 was only available, which had shown modest improvements given that it measured only the first 2 years of progress. This

highlights the need for timely and accurate datasets to be available for target setting and results monitoring.

- *Role of Bank/DPs:* One of the key lessons learned from RCH II was that if managed carefully, the Bank and the DPs can play a constructive and coordinated partnership role in supporting government policies, plans and programs towards agreed goals/outcomes. Agreements such as organizing Joint Review Missions under the leadership of MOHFW, partnering some states with a particular DP, and the technical support from both pooling and non-pooling partners significantly strengthened various program management functions, especially FM and procurement, as well as technical aspects. Such a synergistic partnership proved to be a win-win for both the Bank/DPs and the Borrower and could lead the way for future collaboration on projects in the health sector and beyond in India and in other countries.

Substantial progress has been made on key indicators of importance to achieving the MDGs – maternal and infant mortality in particular. This is true of the polio eradication program as well. Despite these successes, much more needs to be done. For example, for polio eradication, being declared polio free for a year should not be interpreted to mean that these efforts can be relaxed. There are still states that have serious capacity and implementation issues that need further focused action to be able to make the necessary progress. A broad-based platform is in place, and will likely continue in the form of the NRHM. It is now up to the central and state governments to leverage the lessons from the RCH II project to strengthen future efforts. Genuinely empowering states, districts and communities to do so, and paying attention to in-equities is necessary for all future operations, in addition to continuing to strengthen FM and procurement capacities.

7. Comments on Issues Raised by Borrower/Implementing Agencies/Partners

(a) Borrower/implementing agencies

(b) Cofinanciers

(c) Other partners and stakeholders

(e.g. NGOs/private sector/civil society)

Annex 1. Project Costs and Financing

(a) Project Cost by Component (in USD Million equivalent)

Components	Appraisal Estimate (USD millions)	Actual/Latest Estimate (USD millions)	Percentage of Appraisal
Component 1	1,367.00	3,081.00	225.38
Component 2	26.00	30.00	115.38
Component 3	829.00	1,364.00	164.54
Total Baseline Cost	2,222.00	4,475.00	
Total Project Costs	2,222.00	4,475.00	

(b) Financing

Source of Funds	Type of Cofinancing	Appraisal Estimate (USD millions)	Actual/Latest Estimate (USD millions)	Percentage of Appraisal
Borrower		1062.00	3,820.00	359.70
UK: British Department for International Development (DFID)		452.00	260.00	57.52
EC: European Commission		0.00	0.00	
International Development Association (IDA)		*350.00	*370.00	105.71
FOREIGN SOURCES (UNIDENTIFIED)		338.00	25.00	0.00
UN Fund for Population Activities		20.00	25.00	125.00
		2,222.00	4,475.00	

*Discrepancy between appraisal and actual estimates due to SDR exchange rates.

Annex 2. Outputs by Components

Project outputs by component are outlined below. Given the project design and context, many of these are expressed in terms of changes in processes that contribute to systems strengthening, rather than as discrete outputs alone.

Component 1 and 2:

Given that the RCH II project supported the larger RCH II program, progress has been measured against that of the program. There have been several activities under the program and below is the most recent progress made in activities of the program.

At the national level

Program management: Management at the central level has become much more "hands-on" resulting in a continuous search for innovative solutions and improvement. A system of periodic, thematic in-depth reviews of groups of states has been initiated; dedicated teams for visits to states / high focus districts have been set up and 34 high focus districts have been visited. Monthly review Meetings with the State Program officers of all program divisions (maternal health (MH), child health (CH), Immunisation and family planning (FP)) are also being undertaken by National Program Officers particularly for high focus states.

Janani Shishu Suraksha Karyakram (JSSK): In an effort to eliminate out of pocket expenses incurred by pregnant women and parents of sick new- born, MoHFW launched *Janani Shishu Suraksha Karyakram* (JSSK) on 1st June, 2011. Field visits noted satisfactory progress in rolling out of JSSK. JSSK seeks to finance facilities based on a standard costing of agreed inputs to ensure free and cashless deliveries; and hence is a move towards "results based financing" and also rights based entitlement.

The system of allocating flexi funds to states, preparation and appraisal of state PIPs and preparation of quarterly variance analysis reports for major states has shown further improvement. Efforts have been made to reduce overlaps between RCH and Mission Flexi pools. The quarterly variance analysis report for each state, now also provides an assessment of performance of high focus districts. The Operating Manual for preparation and monitoring of state PIPs has been strengthened to also address HR productivity, facility level service delivery, quality and health systems/ management imperatives.

Different aspects of RCH have been under different administrative heads for different periods during the program. Reporting and coordination across cross cutting functions (IEC, M&E, and procurement etc.) could be more effective in meeting RCH program needs.

Results Based Financing has the potential to ensure more efficient use of funds as well as provide the impetus to achieve necessary results. Steps towards RBF would need to address several issues including: (1) transfer mechanisms from states to districts and onwards to facilities and blocks; (2) autonomy for districts and facilities to spend funds to achieve results; (3) maintenance of supply chains; (4) human resource issues; (5) use of private sector capacity; (6) robust contracts/MOUs with strong monitoring; (7) independent verification systems; (8) agreement on a package of services; (9) costing of packages; (10) incentives for quality and equity.

There is lack of integration of MCTS with HMIS; MCTS is seen as an additional exercise. There is also lack of consistency in recording formats within the state and between states. Some states have as many as 38 registers at sub-centre level.

IEC/BCC continues to remain an isolated function at the national and state levels, and the output of the IEC department is rarely integrated into the larger programmatic processes.

Technical strategies

Various maternal health guidelines have been issued and up dated. A Mother and Child Protection card (MCP) has been jointly introduced by MoHFW and DWCD and implementation is well underway. Module 6 and 7 for ASHAs aimed at building their capacity in postnatal and newborn care has been rolled out. A circular has been issued by MoHFW on incentivizing post natal home based visits to ASHAs. Development of separate training materials for doctors, ANM, AWW and ASHA and operational guidelines for IMNCI, F-IMNCI and home based newborn care. MoHFW is also reviving post-partum FP services by initiating the post-partum intra-uterine contraceptive device (PP IUCD) program.

To improve access to contraceptives for the eligible couples, a scheme has been launched to utilize the services of ASHA to deliver contraceptives at the doorstep of beneficiaries. MoHFW has rolled out a new scheme for promotion of menstrual hygiene aimed at ensuring that adolescent girls (10- 19 years) in rural areas have adequate knowledge and information about menstrual hygiene and the use of sanitary napkins.

Other cross-cutting strategies

The proposal for setting up the central procurement agency (CPA) in the form of a registered society has been approved by the Government. A PPP course has been established at the National Institute of Health and Family Welfare (NIHFW) in partnership with DPs. It currently offers an annual course for strengthening the PPP capacity of state and district managers, and has mechanisms for follow-up of trainees and/or providing TA support to states for developing appropriate PPPs. As part of the efforts to build national and state level BCC capacity, a new DP supported initiative -Improving Healthy Behavior Program (IHBP) has been launched. Establishment of a system and culture of quarterly financial reporting has resulted in improvement in the timeliness of financial reporting by states.

At the state level

Program management

Several states (eg Rajasthan, Karnataka, Orissa, J&K) have created teams for more intense supportive supervision. Shortage of HR in rural areas is receiving increased attention across states. Chhattisgarh and Rajasthan have created a special cadre with a mix of financial and non-financial incentives. Haryana, Tamil Nadu and Maharashtra have shown that employment of regular directorate staff can be quick and "strategies or attraction and retention of skilled professionals in rural and remote areas" do not necessarily have to be only through contractual services only.

Tenure and stability of persons holding key posts under NRHM is still an issue across many states. Convergence and coordination with technical officers in State Health Directorate is still not adequate and there is a need to improve it urgently so that quality of technical part of the program improves. Though the number of contractual staff has increased sharply, their productivity and morale could be better. Key underlying factors include: delay in renewal of contracts, poor service conditions and increments, ineffective appraisal system, reluctance to nominate them for longer skill based training, and a wide distinction between contractual and regular staff performing the same tasks.

Technical strategies

States have prepared a list of delivery points in the districts where adequate deliveries are being conducted. These delivery points are to be prioritized and operationalized for providing assured wide ranging RCH services (MH, CH, FP and AH).

Quality of services (equipments/ drugs): Field visits indicate that essential MH drugs are now available in the system. There is more awareness about avoiding routine episiotomy and other such practices. It is encouraging to note increasing practice of AMTSL and maintenance of partograph especially in Madhya Pradesh, West Bengal and Maharashtra among the States visited by JRM states. States are taking steps to include drugs for Medical Abortions into their EDL (Essential Drug List) and supply these drugs at least at identified delivery points where comprehensive RCH services are planned to be provided. All the states have institutionalised the MDR process and have been provided with a monthly monitoring tool to report on the progress being made.

Training:

Skilled Attendance at birth (domiciliary & health facilities): 32291 nursing and Midwifery personnel (Staff Nurse, ANM/LHV) have been trained in SBA, as on Sep, 2011.

Multi-skilling of doctors - 1070 Medical Officers have been trained in LSAS and 601 Medical Officers have been trained in Comprehensive EmOC which includes C-section, as on Sep, 2011.

Ten- day training on Basic Emergency Obstetric Care (BEmOC) Skills has been initiated in the states. Master trainers are now available in most states.

MTP training - A total of 3,588 Medical Officers have been trained on Medical Termination of Pregnancy (MTP) across states during 2009-10 and 2010-11 (till February 2011, as per HMIS data).

Ten- day training on Basic Emergency Obstetric Care (BEmOC) Skills for MOs has been initiated in the states. Master trainers are now available in all states. Numbers of MOs trained in some States are : UP (327), Assam (135), Bihar (81), Rajasthan (62), MP (631), Karnataka (1117), Tripura (10), Nagaland (12)
A total of 516 providers are reported to have received training in Medical Termination of Pregnancy (MTP) across States during April- November 2011 (HMIS), with maximum number trained in Maharashtra followed by UP and MP

The management of training across states remains weak. Comprehensive Training Plans (CTPs) submitted by states are typically prepared in isolation and not aligned with infrastructure upgradation and the HR plans resulting in highly trained resources (MOs trained in LSAS and CEmOC) being confined to facilities where they are not in a position to practice their skills. Database of trained staff is typically not available. Moreover, training needs across all programs are not harmonised. A systematic assessment of impact of training on job performance and skill development is not carried out.

Quality Certification of facilities could be more efficient: States are going in for expensive certification processes ignoring strengthening of their own quality assurance cells and committees. Outside certification is difficult to sustain in the long run and the standards tends to get diluted after certification. The states needs to prioritize certification through in-house quality assurance system and continuous monitoring for the same. Moreover, in some states, both external (ISO/NABH) and internal certification takes place.

Provision of Emergency Obstetric Care- 2891 FRUs and 9107 24X7 PHCs were operational in the country as on March 2011 (NRHM MIS-2010-11). Private sector is also a major player in many states. More than 3000 adolescent friendly health clinics across District Hospitals, CHCs and PHCs are

functional. 5527 Medical Officers and 16728 ANM/LHV/Counsellors have been trained on offering adolescent friendly health services across the country.

Other cross cutting issues

Assam, Karnataka, Jharkhand, Lakshadweep, Tamil Nadu, West Bengal, Mizoram, Goa, Andaman & Nicobar, Gujarat, Bihar, Kerala and Rajasthan have already set-up state level procurement agencies. States have been mainly procuring CH and MH equipment but some states have also procured drugs, medical supplies and minor civil works.

The quality of data in the web based HMIS has shown steady improvement. All 35 states and UTs are uploading data from block level, while several states have commenced facility level data entry. MCTS is being implemented in all the districts visited by JRM. Use of HMIS data is sub optimal. Though there are some efforts in most states to analyze the information from HMIS, and use the analysis for preparation of PIP, the HMIS is typically not being used for monitoring the program at PHC, block, district or state level.

QA committees constituted and notified at the state level in all States. Many states (e.g. MP, Maharashtra) have developed checklists for monitoring.

There is encouraging movement towards making services more accessible to women and vulnerable groups particularly in hilly and difficult to reach areas. The state PIPs and annual budgets demonstrate a stronger focus on reaching vulnerable groups.

Several states have initiated PPPs for addressing critical barriers such as geographical access, gaps in human resources for health, referral transport, and diagnostic and ancillary services. There are several PPPs that have been deployed for strengthening referral transport, contracting in of services at public health facilities, contracting out service delivery to private institutions, social marketing, and developing provider networks. West Bengal and Rajasthan have a PPP policy for health in place.

The existing capacity of undertaking BCC efforts is quite poor in states. Field visits reported need for more efforts at Sub-district Hospital and District Hospital. It also reiterated the need to look at BCC as being beyond stand-alone materials. The visits also identified the need for more focused BCC to be undertaken for improving utilization of services by clients. In some states, teams reported the absence of any communication materials in most facilities.

Component 3:

There has been no case of Wild Polio Virus induced polio since January 13, 2011. India was officially taken of the polio endemic country list by WHO in 2012. Polio coverage in high risk areas has been above 98%, which included the states of UP and Bihar that have all the high risk districts. The success of the polio effort includes strong commitment by the government and all stakeholders, a focused campaign in 107 high risk areas, the introduction of a bivalent vaccine to tackle the two most virulent strains, and a steady focus on migrant populations. In addition, an evidence based approach to planning of immunization campaigns has been followed through the International Expert Advisory Group on polio eradication that helps plan operationally for vaccine procurement and conduct polio campaigns that immunize between 72 to 170 million children every round.

Specific inputs purchased under Bank financing:

1) The Project procured one round of RCH Kit A, Kit B and other kits, cold chain equipment and AD syringes under Bank financing (total value: about US$ 70 Million).

2) Polio vaccines were procured from UNICEF with total value of about US$ 145 Million.

3) Contracts awarded for another round of procurement of kits with cumulative value of about 40 Million US$. However, these were not financed by the Bank (as per request of MOHFW for reallocation of funds for other activities)

4) The remaining credit was used to finance operating expenditures for the program implemented as part of the flexipool available to the states as well as polio operating costs (about USD 20 million for 1 year).

Table A1: Trends in Key Indicators in High Focus States

STATE	Deliveries by skilled Providers			Institutional Deliveries			Any ANC			3 + ANCs			100 Tab IFA		Child Visited within 2 wks	
	DLHS-2	DLHS-3	CES 09	DLHS-2	DLHS-3	CES-09	DLHS-2	DLHS-3	CES-09	DLHS-2	DLHS-3	CES-09	DLHS-2	DLHS-3	DLHS-2	DLHS-3
INDIA	48.0	52.7	76.2	40.5	47.0	72.9	73.4	75.2	87.7	50.1	49.8	63.3	20.5	46.6	na	47.9
Bihar	25.20	31.90	53.2	23.0	27.7	48.3	37.9	59.3	84.3	19.6	26.4	33.8	6.40	46.50	na	26.20
Chhattisgarh	27.10	29.60	56.4	20.2	18.1	44.9	78.9	79.6	98.7	48.7	51.2	71.4	15.90	37.90	na	41.60
Jharkhand	26.70	25.00	47.3	22.4	17.8	40.1	52.2	55.9	87.6	32.8	30.5	57.5	12.00	56.30	na	30.90
Madhya Pd	35.80	50.10	82.9	28.2	47.1	81.0	74.1	61.8	92.3	34.6	34.2	60.0	8.50	49.90	na	37.70
Orissa	40.30	50.90	79.1	34.4	44.3	75.5	75.9	84.1	98.0	47.3	54.6	77.0	20.80	47.90	na	30.60
Rajasthan	43.40	52.70	75.8	31.4	45.5	70.5	68.1	56.1	86.8	33.3	27.7	55.2	7.40	53.70	na	38.20
Uttar Pd	27.40	30.10	64.2	22.4	24.5	62.1	57.8	64.4	71.6	24.7	21.9	38.2	7.90	41.60	na	33.80
Uttarakhand	32.80	35.50	58.7	23.7	30.0	53.5	62.6	55.4	74.6	28.0	32.3	54.8	17.70	33.60	na	31.60

Table A2 : Decline in Total Fertility Rate 2005-2010

	Total					
	2005	2006	2007	2008	2009	2010
India	**2.9**	**2.8**	**2.7**	**2.6**	**2.6**	**2.5**
Andhra Pradesh	2.0	2.0	1.9	1.8	1.9	1.8
Assam	2.9	2.7	2.7	2.6	2.6	2.5
Bihar	4.3	4.2	3.9	3.9	3.9	3.7
Chhattisgarh	3.4	3.3	3.1	3.0	3.0	2.8
Delhi	2.1	2.1	2.0	2.0	1.9	1.9
Gujarat	2.8	2.7	2.6	2.5	2.5	2.5
Haryana	2.8	2.7	2.6	2.5	2.5	2.3
Himachal Pradesh	2.2	2.0	1.9	1.9	1.9	1.8
Jammu & Kashmir	2.4	2.3	2.3	2.2	2.2	2.0
Jharkhand	3.5	3.4	3.2	3.2	3.2	3.0
Karnataka	2.2	2.1	2.1	2.0	2.0	2.0
Kerala	1.7	1.7	1.7	1.7	1.7	1.8
Madhya Pradesh	3.6	3.5	3.4	3.3	3.3	3.2
Maharashtra	2.2	2.1	2.0	2.0	1.9	1.9
Odisha	2.6	2.5	2.4	2.4	2.4	2.3
Punjab	2.1	2.1	2.0	1.9	1.9	1.8
Rajasthan	3.7	3.5	3.4	3.3	3.3	3.1
Tamil Nadu	1.7	1.7	1.6	1.7	1.7	1.7
Uttar Pradesh	4.2	4.2	3.9	3.8	3.7	3.5
West Bengal	2.1	2.0	1.9	1.9	1.9	1.8

Source: SRS 2010

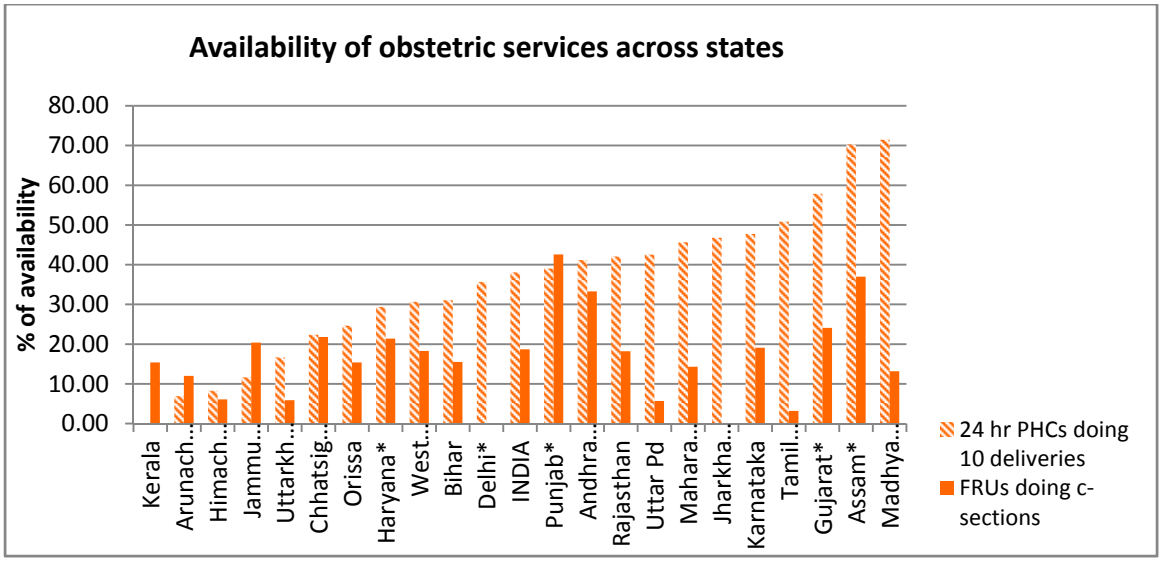
Note: Shaded states are EAG states.

Table A3 : Functional status and availability of key inputs for quality obstetric care services in the public sector

Indicator	India		High Focus non-North East (10 States)		Non-High Focus non-North East (10 States)	
	Number	Percentage	Number	Percentage	Number	Percentage
1	2	3	4	5	6	7
No of sub centers (S.C.)*	**146036**	**100**	**70085**	**47.99**	**68137**	**46.66**
S.C. with 2 ANMs	40426	27.68	15537	22.17	21117	30.99
Contractual ANMs recruited	46690	31.97	15796	22.54	23888	35.06
No of Primary Heath Centers (PHCs)*	**23458**	**100**	**11376**	**48.50**	**10625**	**45.29**
PHCs functioning 24x7 basis	8324	35.48	2863	25.17	4808	45.25
PHCs without a doctor*	2533	10.80	2136	18.78	323	3.04
PHCs where 3 staff nurses have been appointed	5907	25.18	1161	10.21	4188	39.42
No of Community Health Centers(CHCs)*	**4276**	**100**	**1978**	**46.26**	**2049**	**47.92**
CHCs functioning on 24x7 basis	3966	92.75	1714	86.65	1981	96.68
CHCs functioning with 3 staff nurses	1192	27.88	166	8.39	1000	48.80
Number of CHCs and others working as FRUs	1122	26.24	328	16.58	746	36.41
District Hospitals	517	**100**	295	**57.06**	182	**35.20**
District Hospitals functioning as FRUs	510	98.65	256	86.78	176	96.70

Percentages highlighted in bold are from numbers across column categories
Percentages not highlighted in bold are based on comparisons across rows in the same column
*Information from Rural Health Service Bulletin-2008, All other information based on All India Summary of NRHM Programme-31/10/2010

Figure A1: Infrastructure for Institutional Deliveries



Source: DLHS-3 (2007-08)

Cesarean section is an essential component of comprehensive obstetric care. Data from HMIS (Table below) shows that there is an improvement in the number of district hospitals, sub district hospitals conducting cesarean sections. An increasing number of facilities have been upgraded to provide these services. However, there is an issue regarding the quality of service being provided in these facilities.

Indicator	Quarter 1 (2011)	Quarter2 (2011)	Quarter 3(2011)
District Hospitals conducting at least 20-C.Sections in a quarter	51.7%	50.8%	49.1%
% of upgraded FRUs offering 24 hrs. emergency obstetric care	16.0%	40.0%	40.9%

Annex 3. Economic and Financial Analysis

2005-06 marked a turning point for the health sector in India when the government of India launched the national flagship program called the National Rural Health Mission (NRHM) with the aim of strengthening public health service delivery in rural areas. The strong political commitment led to the adoption of an explicit health financing goal to step up public health spending from 1% of GDP in 2004-05 to 2 - 3% of GDP by 2011-12. As a result, public health spending has grown substantially (by around 20% per annum in nominal terms) since 2005-06. RCH II and NRHM have been operational for about the same length of time--about seven years. During this period, the share of central government financing for public health rose to nearly 35%, the balance being contributed by states from their own budgets. 63% of total central health spending was on NRHM and nearly 70% of total NRHM funds were for RCH-related activities during 2005-06 and 2011-12. "Pooled" RCH financing from external donors, including the Bank financing, went into the "RCH flexi-pool" that accounted for 19% of total NRHM allocations (refer table 1 below). MOHFW's total budget as well as NRHM budget nearly tripled during 2005-06 to 2011-12.

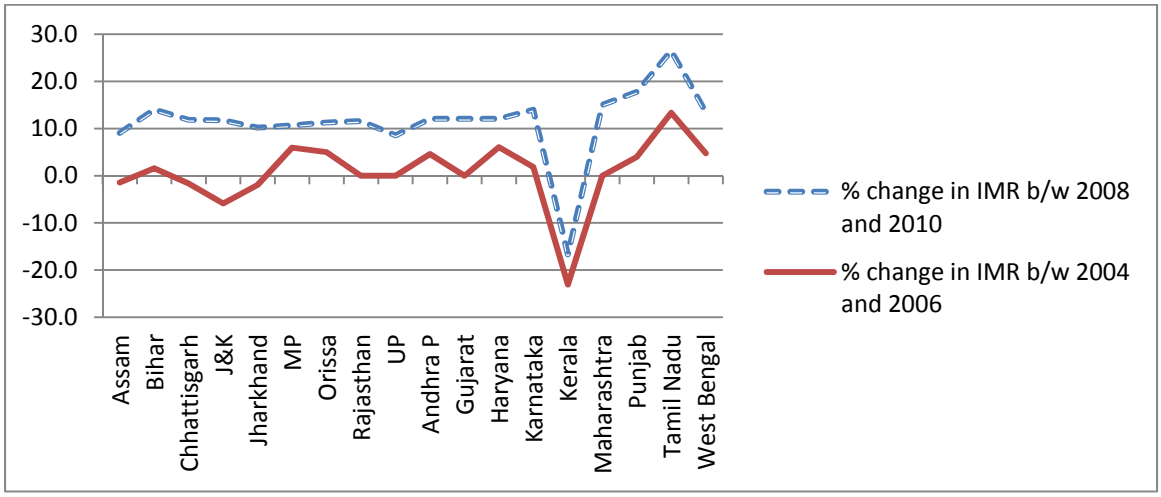
Table A4: Central budget allocations by selected heads

						Figures in US$ million#		
	2005-06	**2006-07**	**2007-08**	**2008-09**	**2009-10**	**2010-11**	**2011-12**	**2012-13**
MoHFW Budget	2137	2599	3171	3625	4528	5031	6091	6898
NRHM budget	1291	1807	2186	2395	2800	3103	3585	4126
RCH (in general)*	1097	1303	1423	1726	1919	2109	2264	2691
RCH Flexipool (Don	123	306	295	447	610	679	761	869
Polio Immunization	61	84	71	92	91	79		
					Percentage shares			Cumulative
	2005-06	**2006-07**	**2007-08**	**2008-09**	**2009-10**	**2010-11**	**2011-12**	Share
NRHM's share in MoHFW budget	60.4	69.5	68.9	66.1	61.8	61.7	58.9	63.2
RCH's share in NRHM budget	85.0	72.1	65.1	72.0	68.5	68.0	63.2	69.0
Flexi-pool's share in NRHM budget	9.5	16.9	13.5	18.7	21.8	21.9	21.2	18.8
*NRHM budget less budget of Administration, NRHM flexi-pool, and National Disease Control Programs								
#Exchange rate used in conversion of INR into US$ is I$ = INR 50								

The illustrative analysis below looks at IMR reduction since data on IMR is available with greater frequency and through the Sample Registration System, and is considered more robust than MMR. Comparing percentage reductions in IMR across 18 major states at two different periods of time, i.e., prior to the project and during the latter part of the project period, show a definite increase in IMR reduction across all the states considered.

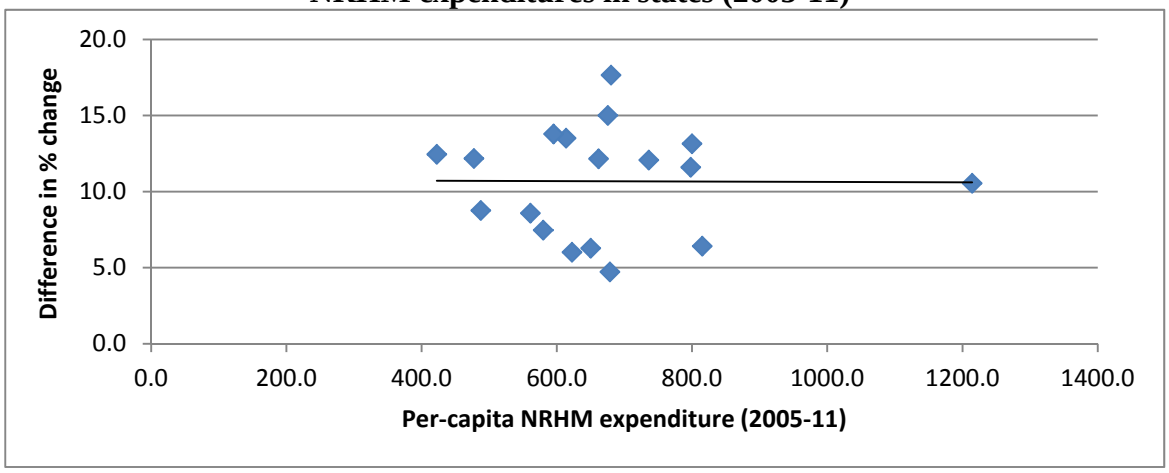
The graph below shows percentage reduction in IMR between 2004-06 and 2008-10.

FigureA2: Percentage reduction in IMRs between 2004 and 2006 and between 2008 and 2010



However, a quick analysis (Figure A3 below) suggests no correlation between IMR reduction across states and per-capita NRHM expenditures, 70% of which is meant for RCH-related activities. This should not come as a surprise given that IMR reduction is a function of not just health sector spending but also spending on other determinants of health. It may also be indicative of progressive targeting of resources to the highest-burden states.

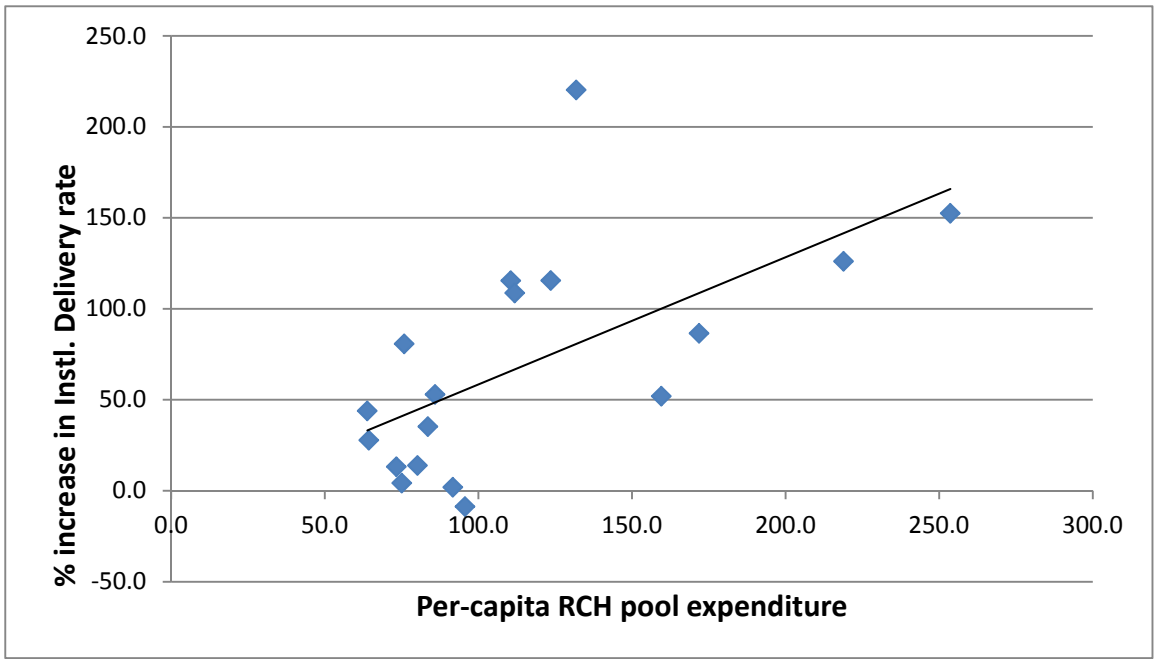
Figure A3 Percent change in IMR between 2004-06 and 2008-10 vs. per-capita NRHM expenditures in states (2005-11)



An analysis of per-capita RCH flexi-pool expenditures and increase in the rate of institutional deliveries across states between 2005-06 and 2010-11 does show a high

positive correlation (0.614) (refer FigureA4 below)[10] suggesting that the RCH-flexi-pool resources may have contributed to the observed increase in institutional deliveries.

Figure A4: Per-capita RCH pool expenditure vs. percentage increase in rate of Institutional Deliveries



Under the Pulse Polio Program (component 3 of RCH II), of the cumulative expenditures from 2005-06 to 2010-11, a little more than 50% went only to Bihar and Uttar Pradesh – the two states from where the Polio cases were still being reported – that were holding the country back from achieving Polio-free status. Project restructuring in May 2010 was reallocated additional project funds to finance Polio operating costs to be disbursed on the basis of number of children immunized at standard costs. Some of these project contributions were critical for the final push for achieving a polio-free India.

[10] NFHS-3 data were used for institutional deliveries 2005-06; and MIS and census 2011 data were used for institutional delivery rates for 2010-11.

Annex 4. Bank Lending and Implementation Support/Supervision Processes

(a) Task Team members

Names	Title	Unit
Lending		
Sadia Afroze Chowdhury	Task Team Leader	SASHD
Hugo Diaz-Etchevehere	Consultant	OPCIL
Sara M. McKinley	Junior Professional Associate	SASHD
Gandham N.V. Ramana	Lead Health Specialist	AFTHE
Supervision/ICR		
Meera Shekar	Lead Health and Nutrition Specialist	AFTHW
Peter A. Berman	Lead Economist, Health	HDNHE
Asha Bhagat	Consultant	SARFM
Meera Chatterjee	Senior Social Development Spec	SASDS
Victoria Francis	Consultant	SASHD
Mohan Gopalakrishnan	Senior Financial Management Specialist	SARFM
Gerard Martin La Forgia	Lead Health Specialist	EASHH
Shanker Lal	Senior Procurement Specialist	SARPS
Onika Vig Mahajan	Program Assistant	SASHD
Varinder Kumar Manchanda	Consultant	SASHN
Arun Manuja	Senior Financial Management Specialist	SARFM
Shyama Nagarajan	Health Specialist	SASHN
Snehashish Rai Chowdhury	Consultant	SASDI
Roselind Rajan	Program Assistant	SARDE
Vikram Sundara Rajan	Senior Health Specialist and TTL	SASHN
Gandham N.V. Ramana	Lead Health Specialist	AFTHE
Birte Holm Sorensen	Consultant	AFTHE
Ruma Tavorath	Senior Environmental Specialist	SASDI
Yolanda Tayler	Manager	MNAPR
Elfreda Vincent	Program Assistant	SASHD

(b) Staff Time and Cost

Stage of Project Cycle	Staff Time and Cost (Bank Budget Only)	
	No. of staff weeks	USD Thousands (including travel and consultant costs)
Lending		
FY04		248.46
FY05		383.52
FY06		122.91
FY07		63.25
Total:		**818.14**
Supervision/ICR		
FY07		174.91
FY08		210.76
FY09		283.09
FY10		159.17
FY11		127.05
FY12		174.72
Total:		**1129.70**

Annex 5. Beneficiary Survey Results
Done at preparation phase.

Annex 6. Stakeholder Workshop Report and Results
Although no ICR stakeholder workshop was held, a COSO workshop was held with partners. A summary of the observations is attached below.

COSO Workshop summary:

Summary Observations By the Workshop Facilitators
The Reproductive and Child Health (RCH) II Project has suffered significant setbacks due to poor timing of the project with efforts of its counterpart, the Government of India's National Rural Health Mission (NRHM) and delays in disbursement because of restrictive controls imposed by the Bank in the post-DIR era. These problems are the result of both the investigation of RCH I and the DIR with the result that the RCH II Project approval was delayed by a year and conditions and restrictions were imposed on the project that were not present in the original design. The workshop included not only members of the Bank project team, but also participants from DFID and UNFPA, partners in the larger program of which the Bank's RCH II project is a part.

The program team is nonetheless convinced that the program can move forward and cited the following key strengths: its strong technical design, good coordination and teamwork amongst the pooling partners, and the importance of health in the overall government agenda. The key challenges are working out the appropriate roles of RCH and NRHM so that the two programs are working together, rather than in competition with each other; learning how to function effectively in the post-DIR environment of restrictive controls; and working in an environment of uneven client capacity which can make it difficult to disburse in states with poorer capacity, even though these states may be the ones in most need.

Strengths, Challenges, Risks, and Opportunities
Strong Technical Design – Participants are confident of the project's strong technical design with its evidence-based approach and focus on decentralization. Participants feel that while the money may not be moving, they do see change happening on the ground.

Donor Coordination Amongst Pooling Partners – Participants feel that teamwork amongst the pooling partners (World Bank, DFID, UNFPA) is strong and that this teamwork can help the program deal with difficulties that arise. They recognize that each team member has something to bring to the table and that, overall, the use of sector-wide approaches in coordination with partners is still a good idea. They look to take advantage of the pooled nature of the funds to manage some of the challenges created by restrictions on each individual partner's focus or ability to direct funds. This will allow the partners to do more together than what they can achieve separately. They also recognize the need to have a common voice with the client and have suggested using thematic groups to do this.

Importance of Health on Government Agenda – Health is an important issue in the Government of India's agenda, with a focus on decentralization that dovetails with the RCH program design. States are increasingly interested in trying new approaches and are committed to achieving the health outcomes of the program.

Roles of RCH and NRHM – Because of the delays in startup for RCH, the NRHM was established and functioning before the RCH program. Practices and procedures which were intended to be consistent between the two programs are now inconsistent. Combined with this, there are structural disincentives for the key figures at the top of these two programs to work together effectively to resolve the inconsistencies.

Uneven Client Capacity – An additional challenge that the program faces is uneven client capacity, where the states most in need of the program's support, are the states which may be least capable of meeting the Bank's policies and procedures. Participants recognize the need to help the client build systems which are capable of meeting the Bank's requirements.

Post-DIR Environment – In the post-DIR environment, the program is finding it difficult to disburse funds because of restrictions imposed by Senior Management at the Bank. Participants discussed creative ways to address this problem, including seeking out ways for the Bank to find items which it can fund under existing rules (for example, changing restrictions in the project to fund items such as vaccines which can functionally be funded under existing Bank FM and Procurement rules) and encouraging the Bank to relax some of the most restrictive policies. The also look to establish a Secretariat to help manage the fiduciary and monitoring issues in the project, allowing technical staff to focus more on the project content. In the long term, participants believe that if the Bank is truly to have developmental impact in the area of governance, it must focus on country systems improvement rather than ring-fencing of projects.

Annex 7. Summary of Borrower's ICR and/or Comments on Draft ICR

Background

1. Launched in April 2005 in partnership with the state governments, Reproductive and Child Health, Phase II (RCH II) was a comprehensive sector wide flagship programme, under the bigger umbrella of the Government of India's (GoI) National Rural Health Mission (NRHM), to deliver the RCH II targets for reduction of maternal and infant mortality and total fertility rates. RCH II aimed to reduce social and geographical disparities in access to, and utilisation of quality reproductive and child health services.

2. The design of RCH II was built on the lessons learnt from RCH-I. The paradigm shift envisaged in RCH II included:

- Ensuring a more explicit pro-poor focus
- Evolving a shared vision and a common programme covering the entire family welfare sector, the Sector Wide Approach (SWAp)
- Focusing on results (outcomes rather than inputs)
- Using evidence to prioritize interventions and shift resources to where the health outcomes are worst and the need is greatest
- Moving away from 'top down' to a 'bottom up' planning approach that gives flexibility for the states to evolve programmes based on their contextual needs.
- Introducing concepts of performance based funding
- Encouraging innovative approaches, including partnerships with private sector, to improve reproductive and child health outcomes among scheduled castes and tribes
- Effective communications to bring about behaviour change
- Monitoring of the programme by multiple organisations (departmental reports, independent surveys and community monitoring) to track equitable access by and outreach to excluded groups.
- Strengthening of health systems to support RCH outcomes under the umbrella of NRHM

3. RCH II was largely financed by GoI with support from DFID, World Bank, UNFPA, UNICEF, WHO, EC, USAID, NIPI and JICA.

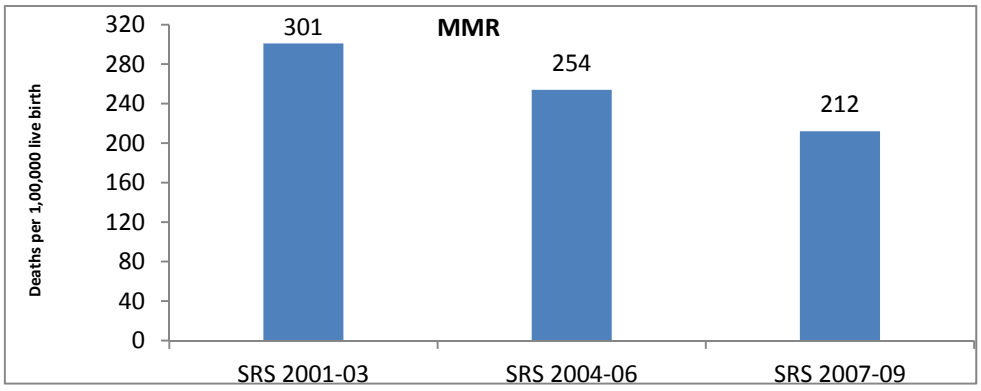
Progress and Results

RCH II Goals

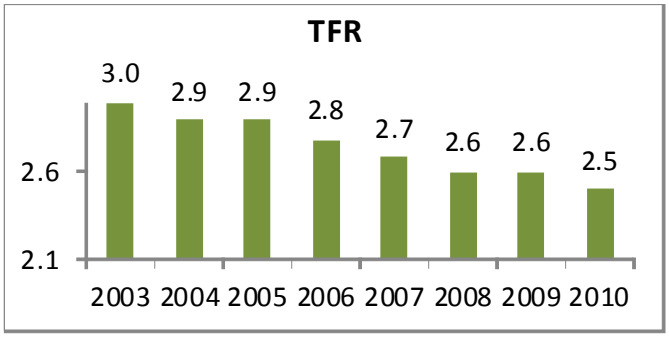
4. India's MMR at 212 (SRS 2007-09) has improved significantly from 254 (SRS 2004-06), IMR at 47 (SRS 2010) has improved from 58 (SRS 2004), while TFR at 2.5 (SRS 2010) has improved from 2.9 (SRS 2004):

5. Kerala and Tamil Nadu have achieved the RCH/NRHM 2012 goal for MMR. 12 States and UTs (Kerala, Goa, Tamil Nadu, Manipur, Nagaland, A&N islands, Chandigarh, Daman & Diu, Lakshadweep, Puducherry, Maharashtra and Tripura) have achieved the goal for IMR whereas Delhi and Sikkim have IMR of 30. Twenty-one states and UTs have achieved national goal for TFR (Tamil Nadu, Kerala, Himachal Pradesh, Andhra Pradesh, West Bengal, Maharashtra, Karnataka, Punjab, Goa, Chandigarh, Puducherry, Andaman & Nicobar Islands, Sikkim, Manipur, Mizoram, Nagaland, Tripura, Daman & Diu, Lakshadweep, J & K and Delhi). Only Kerala and Tamil Nadu have achieved all the three RCH goals. However, the results do not reflect the full impact of RCH-II interventions.

6. MMR trend analysis[11] shows accelerated progress in RCH II period in Assam, UP/Uttarakhand, Rajasthan, Madhya Pradesh/Chhattisgarh, Karnataka, Haryana, Maharashtra and Punjab. Some of the states are closer to the RCH goals than others e.g. 4 states i.e. Andhra Pradesh, West Bengal, Gujarat and Haryana have MMR ranging from 134-153 (SRS 2007-09); eight states/UTs (Karnataka, Punjab, West Bengal, Arunachal Pradesh, Himachal Pradesh, Mizoram, Uttarakhand and DNH) have IMR ranging from 31 to 40(SRS 2010); four states (Haryana, Gujarat, Odisha and Assam) have TFR ranging from 2.2 to 2.6(SRS 2010).

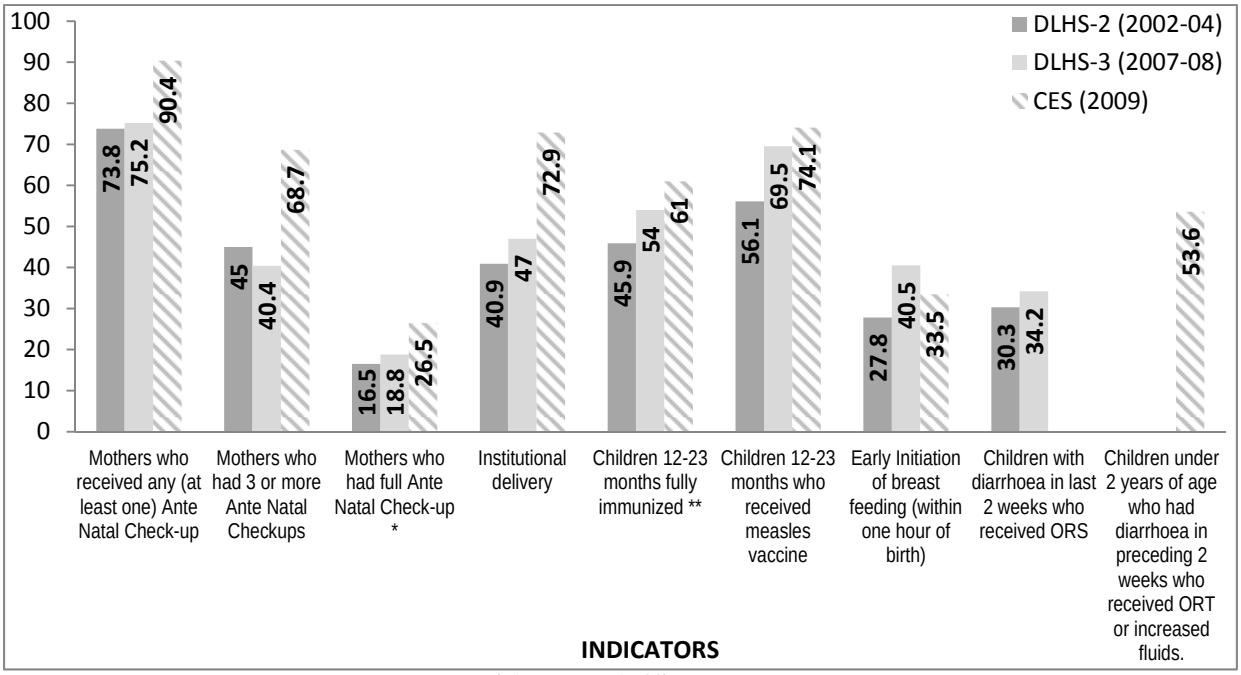


[11] Comparison of SRS 2001-03 to 2004-06 and 2004-06 to 2007-09



RCH II Outcomes

7. The Coverage Evaluation Survey (CES) 2009 (commissioned by UNICEF) showed significant improvement from the midline (DLHS 3, 2007-08) and the base line DLHS-2 (2002-04) results, although these are strictly not comparable.



(Figures are in %)

* At least three antenatal checkups, one TT injection and consumed 100+ IFA tablets
** 1 dose of BCG, 3 doses of DPT, 3 doses of polio (excluding 0 dose), and 1 measles injection
# Oral rehydration Salts Solution

Assessment of implementation progress

8. The paradigm shift envisaged under RCH II has largely taken place :

Reducing disparities

- GoI had identified 18 high focus states with poor socio-demographic indicators, for enhanced financial and technical assistance: UP, Bihar, MP, Orissa, Rajasthan, Chhattisgarh, Jharkhand and Uttaranchal; the 7 North East states, Sikkim, Himachal Pradesh and Jammu & Kashmir.

- In addition, 264 backward districts were identified by MoHFW for special attention as High Focus districts. GoI led multidisciplinary teams made about 30 visits in HF districts (2010-12) to facilitate preparation of detailed district plans including facility wise analysis of HR, training, infrastructure & equipment, referral transport. High focus districts were allotted greater share of budget.

- GoI also encouraged states to identify and list high priority facilities for operationalisation based on appropriate criterion. State wise list of delivery points prepared and States were asked to plug all gaps for assured delivery of all RCH services.

- The state PIPs and annual budgets demonstrated a stronger focus on reaching vulnerable groups.There was an encouraging movement towards making services more accessible to women and vulnerable groups particularly in hilly and difficult to reach areas.

Strengthening results measurement

- GoI took the initiative of getting a shared commitment from States on the physical targets for various approved interventions / activities to be implemented. All states/UTs set targets for IMR, MMR and TFR as well as underlying indicators such as institutional deliveries; and spell out strategies and activities for meeting targets. Moreover, the approval of the programme implementation plans (PIPs) for NRHM, including for RCH II, for the year 2010-11 onwards reflected this commitment in the form of clearly defined "Monitorable Indicators" and "expected outputs" for each approved activity, along with the corresponding budget. States reported on the physical progress and financial expenditure in the next year's PIP, against these monitorable indicators and expected outputs.

Pro-poor focus and a move towards results based financing

- In an effort to eliminate out of pocket expenses incurred by pregnant women and parents of sick new- born, MoHFW launched Janani Shishu Suraksha Karyakram (JSSK) on 1st June, 2011. JSSK seeks to finance facilities based on a standard costing of agreed inputs to ensure free and cashless deliveries; and hence, is seen as a move towards "results based financing" (RBF)[12] where outputs are financed rather than provision of inputs irrespective of the need at the facility level.

[12]The RCH II program had envisaged a performance based bonus to states based on achievement of 3 suggested indicators related to utilization of funds, institutional deliveries and immunization. These were to

Bottom-up planning approach and flexibility

- Decentralised planning processes were put in place in most of the states. Continuous progress in the quality and number of District Health Action Plans was observed with the number increasing from 284 in 2006-07, to 488 in 2007-08 to 636/640 in 2011-12. Several states (eg Gujarat, MP, Orissa) had extensive consultations at district and sub-district levels in the preparation of the PIP.

- As envisaged the National Program Coordination Committee at central level appraised and approved all the State PIPs and provided program oversight. The system of allocating flexi funds to states, preparation and appraisal of state PIPs and preparation of quarterly variance analysis reports for major states showed improvement over the years. Efforts were made to reduce overlaps between RCH and Mission Flexi pools. The quarterly variance analysis report for states was revised to include an assessment of performance of high focus districts.

Programme Management Arrangements

- At the central level Health and Family welfare was merged under one department and one secretary.

- The States also put the necessary structures and systems in place to support a more flexible and comprehensive sector-wide approach. In all the states the vertical societies existing for various programmes were merged into one State Health Society. Similarly at the district level one District Health Society was created by merging the district level vertical societies.

- All states used the flexibility provided under RCH II to strengthen staffing levels through establishment of state and district program management support units and this has contributed to the increase in absorptive capacity/ expenditure. Many States also established regional and block programme management units. Infusion of managerial cadre and their involvement in day to day work has contributed immensely towards better implementation of RCH II/NRHM.

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be started in the fiscal year 2007-08, after the institutional mobilization phase. However, with the increased financing made available under the NRHM, the use of this model of performance based financing was not considered as a relevant model for implementation.

Technical support and monitoring

- GoI provided handholding support to the States in management of RCH in continuous search for innovative solutions and improvement. Regular workshops (for MH, CH, FP, AH and PNDT) with state level counterparts; a system of periodic, thematic in-depth reviews of groups of states; dedicated teams for supportive supervision to states / high focus districts were some of the steps taken to strengthen supportive supervision. DPs also provided technical assistance/ supportive supervision in selected high focus districts/States.

- Capacities of program divisions at the central level were strengthened with dedicated Deputy Commissioners for MH, CH, FP, AH, Immunization and training supported by Assistant Commissioners and over 60 consultants on contract.

- National Health Systems Resource Center (NHSRC) provided timely and effective technical assistance and did several studies and action research.

- Technical and Management Support Agency (TMSA) provided technical assistance.

Strengthening of Monitoring & Evaluation (M&E) systems

- Overall, monitoring of the RCH II program was strengthened by introduction of web-based Health Management and Information System (HMIS). Since its introduction in 2008, the quality of data in the web based HMIS has shown steady improvement. All 35 states and UTs are uploading data from block level, while several states have commenced facility level data entry.

- 'Mother and Child Tracking System (MCTS)' was initiated in 2011 and is now being implemented across all the States and districts. MCTS was rolled out to track every pregnant woman by name for provision of timely ANC, Institutional Delivery, and PNC along-with immunization of the new- born. Data for around 2.55 crore pregnant women and for 1.85 crore children have been captured on the MCTS.

- Data from the Annual Health Survey (2010-11) was released in 2011 which covers 9 states and all the districts in these nine states. The fact sheets were released in 2011 whereas detailed state-wise and district-wise reports were released in 2012. Some disaggregated indicators are in the process of being

released. AHS would provide the necessary data annually which would be used in better planning.

Procurement

- Central Procurement Agency (CPA) has been registered in the form society.

- Many states have set-up state level procurement agencies e.g. Assam, Karnataka, Jharkhand, Lakshadweep, Tamil Nadu, West Bengal, Mizoram, Goa, Andaman & Nicobar, Gujarat, Bihar, Kerala and Rajasthan.

Quality

- Quality Assurance Committees were constituted and notified at the state and district level in all States. Many states (e.g. MP, Maharashtra) have developed checklists for monitoring.

- Several initiatives are seen across states to improve quality of RCH services. Gujarat has a quality assurance manual in place for RCH and there is focus on total quality management and accreditation of PHCs and CHCs. MP and Odisha has set up a QA Program, wherein District Hospitals are being strengthened to meet NABH accreditation standards. Steps taken by Maharashtra include standard treatment protocols and grading of PHCs based on service quality parameters.

- NHSRC has been in the process of implementing quality management system at all level across the country. It has successfully completed certification of 80 health facilities across the various states.

Public Private Partnerships

- Several states initiated PPPs for addressing critical barriers such as geographical access, gaps in human resources for health, referral transport, and diagnostic and ancillary services. Several PPPs were deployed for contracting in of services at public health facilities, contracting out service delivery to private institutions, social marketing, and developing provider networks. Gujarat, West Bengal and Rajasthan have a PPP policy for health in place.

- Private institutions contributed increasingly towards RCH service delivery. In 2010-11, private accredited health institutions accounted for 25% of institutional deliveries in both public and private accredited facilities; the corresponding share for sterilisation services is 16%.

- A PPP course was established at the National Institute of Health and Family Welfare (NIHFW) in partnership with DPs. It offered an annual course for strengthening the PPP capacity of state and district managers, and had mechanisms for follow-up of trainees and/or providing TA support to states for developing appropriate PPPs.

Innovations

- The flexibility provided under RCH II was well utilised and almost all the states have implemented an impressive range of innovative approaches in order to address local needs/ gaps in health services There were more than 100 innovations across various thematic areas ranging from referral transport, safe motherhood and maternal mortality reduction, Immunization and infant and young child feeding, adolescent reproductive and sexual health (ARSH), service delivery for RCH, and program management.

- Shortage of HR in rural areas received increased attention across states. Chhattisgarh and Rajasthan created a special cadre with a mix of financial and non-financial incentives. Haryana, Tamil Nadu and Maharashtra showed that employment of regular directorate staff can be quick and "strategies for attraction and retention of skilled professionals in rural and remote areas" do not necessarily have to be only through contractual services only.

- Maharashtra and Karnataka have passed legislations wherein a minimum tenure has been stipulated before transferring out Health Department personnel. Bihar and MP upgraded Post Graduate Medical Officers to specialist cadre to ensure utilisation of anesthetists, gynecologists and pediatricians in their respective areas of specialisation. Madhya Pradesh (MP), Gujarat and Maharashtra decentralized recruitment of staff nurses and ANMs to district level.

Financial Management

- E-Banking/FMIS Application – E-transfers of funds under RCH/NRHM was undertaken up to District, and even block level in all states. E-Banking Management Information System has been developed. It has substantially reduced the lag in delay in release of funds post approval.

- Establishment of a system and culture of quarterly financial reporting resulted in improvement in the timeliness of financial reporting by states.

- Utilization of funds- RCHII expenditure increased more than 5 times in 5 years: from Rs. 885 crores (audited expenditure in 2006-07) to Rs. 4573 crores (reported expenditure for 2011-12).

- JSY expenditure which increased by almost 6 times from Rs 256 crores in 2006-07 to Rs. 1474 crores in 2009-10 and Rs. 1553 crores in 2010-12 respectively.

- States of MP and Assam providing cash assistance to JSY beneficiaries through A/c payee cheques. Further, the ASHAs are being paid via A/c payee cheque the states of Andhra Pradesh, Assam, Uttarakhand, Bihar, Jharkhand, Madhya Pradesh, Chhattisgarh, Orissa, Mizoram, Punjab, Tripura, Jammu & Kashmir.

- The MoHFW has uploaded several handy finance manuals / guidelines which are useful to even below block levels.

- Model Accounting Handbooks for sub-district level finance/accounts personnel at Sub Centers, CHCs/PHCs, and Block Accountants were rolled out for guidance and capacity building at states.

- Detailed Operational Guidelines on Financial Management to improve the Financial Management System was disseminated.

- E-training modules on finance and accounts under NRHM introduced and uploaded on Ministry's site to build financial management capacities among finance personnel.

Community Monitoring

- The process of community monitoring was initiated with specific objectives to provide, regular and systematic information about community needs, feedback according to locally developed parameters, feedback on the status of fulfilment of entitlements, functioning of various levels of the public health system, identify gaps/deficiencies in the services and levels of community satisfaction and increase responsiveness of the public health system. The system has monitored the demand, coverage, effectiveness, behaviours and presence of health care personnel, quality and possible denial of care and negligence at the state, district, Block, PHCs and villages levels.

- Community monitoring was seen as a key strategy for ensuring accountability and ownership of the RCH II/ NRHM program. Many States engaged community and PRIs in monitoring of health programs and management of health facilities. The first phase of the community monitoring covered 9 states and there has been

evidence of improvement in the quality of service delivery, infrastructure, service utilization.

Convergence

- Efforts were made for convergence with other departments. Common MCH card was released jointly by MoWCD and MoHFW. Additionally, discussions were held with MoWCD in the areas of nutrition, and menstrual hygiene scheme.

- As breastfeeding reduces neo-natal mortality, exclusive breastfeeding for first six months and appropriate infant and young child feeding practices are being promoted in convergence with Ministry of Woman and Child Development.

Technical strategies

- Many policy decisions were taken to improve the RCH service delivery. It included policy decision taken to permit the Staff nurses and ANMs to manage some common obstetric emergencies and administer injections (e.g. Injection Oxytocin), Life Saving Anesthestic Skills and EmOC training to MBBS doctors to provide life saving Emergency Obstetric Care, use of Zinc along with ORS to address high diarrhoeal morbidity and mortality, acute respiratory infection guidelines updated to address high respiratory infection and pneumonia etc.
- Many guidelines and training materials were developed and updated to help the health personnel provide better RCH services. E.g. SBA training material and training video, operational guidelines for facility-based & home based neo-natal care, operational guidelines for IMNCI, F-IMNCI etc.
- Medical abortion drugs were included in Essential Drug List (EDL) of many states.
- Various field visits including JRM/CRM indicated availability of essential RCH drugs. Increasing practice of Active Management of Third Stage of Labour (AMTSL) and maintenance of partograph were reported from many states.

- Many States especially MP, Rajasthan, Orissa and Bihar have shown particularly impressive increases in institutional deliveries. A major contributing factor has been the conditional cash transfer scheme called 'Janani Suraksha Yojana' (JSY). From a modest beginning of 7.39 lakh beneficiaries in 2005-06, the number has risen more than ten-fold to 109.37 lakh beneficiaries under JSY in 2011-12. This surge in demand for institutional deliveries coupled with interventions on the supply side (such as skill development, additional human resources, etc.) has laid an excellent foundation to reduce maternal and new born morbidity and mortality.

- Programmatic interventions were made to address HR shortages. Multi skill training of doctors in EmOC and Life Saving Anaesthesia Skills (LSAS) and "task shifting" to auxiliary nurse midwives (ANMs) and nursing personnel with special reference to skilled birth attendance (SBA) is gained momentum in the later years of RCH II. The States trained almost 1307 LSAS, 809 EmOC and 40556 SBAs.

- Access to Emergency Obstetric Care (EmOC) has been enhanced through operationalising FRUs and 24-hour services at PHCs. 8475 PHCs were made operational 24x7(March 2012) as against 1263 in March 2005 whereas 2315 First referral units (FRUs) were functional in March 2012 as against 955 in March, 2005 (Source: NRHM MIS 2012). Private sector is also a major player in many states.

- Services for early detection of pregnancy were introduced and field visits indicate availability of pregnancy detection kits (Nischay) with peripheral health functionaries.

- Referral transport systems, in general were strengthened across states. After the advent of JSSK almost all the State have made arrangements for free transportation of pregnant women to the health facility for delivery as well as for drop back/referral to a higher facility.

- Module 6 and 7 for ASHAs aimed at building their capacity in postnatal and newborn care was rolled out. Under Home Based New Born Care (HBNC) ASHA make visits to all newborns according to specified schedule up to 42 days of life.

- In order to strengthen Facility Based Newborn and Child Care following have been established:
    - ❖ 374 Sick New Born Care Units (SNCUs)
    - ❖ 1638 New Born Stabilisation Units (NBSUs)
    - ❖ 11432 New Born Care Corners (NBCs)

- 564 Nutritional Rehabilitation Centres (NRC) were established to treat severe acute malnutrition amongst children.

- No case of polio has been reported since January 2011. India was officially struck off from the list of polio endemic country in 2012 by WHO.

- Total fertility has decreased and a strong two-child norm culture is beginning to take hold. Use of any modern method improved over DLHS-2. However, in all

states, female sterilization remained the major contributor, although some states are showed positive trends in NSV uptake. There has been greater use of spacing methods in urban areas.

- States have implemented a range of strategies to provide regular service delivery including creating district level teams of laparoscopic surgeons and fixed-day static services. Innovative initiatives to improve awareness of FP include FP counsellors located at CEmONCs in MP; Jan Mangal couples in Rajasthan as community-level FP "counsellors" and also serving as contraceptive depot holders.
- MoHFW revived the post partum FP services by initiating the post partum intra-uterine contraceptive device (PP IUCD) programme.
- A new scheme of "delivery of contraceptives (condom, OCP and ECP) by ASHA at doorstep" in 233 districts of 17 states. Implementation is underway in 166 districts.
- MoHFW rolled out a new scheme for promotion of menstrual hygiene aimed at ensuring that adolescent girls (10- 19 years) in rural areas have adequate knowledge and information about menstrual hygiene and the use of sanitary napkins. This scheme has been implemented in 152 districts across 20 states.
- More than 3000 adolescent friendly health clinics were made functional. 5527 MOs and 16728 ANM/LHV/Counsellors were trained on adolescent friendly health services (AFHS). In many states peer educators were trained to support AFHS (Adolescent Friendly Health Services).

- MoHFW rolled out Weekly Iron and Folic Acid Supplementation (WIFS) Programme to meet the challenge of high prevalence and incidence of anaemia amongst adolescent girls and boys. The long term goal is to break the intergenerational cycle of anaemia, the short term benefits is of a nutritionally improved human capital. The programme, implemented across the country both (rural and urban areas) will cover 12.72 Crores adolescents 5.74 Crore girls and boys enrolled in class VI-XII of government and government aided school and 6.97 Crores out of school girls.

PERFORMANCE OF THE WORLD BANK

- There was a clear commitment from the World Bank and other Development Partners (DPs) to support the RCH programme in a sector wide manner and to align the resources and programme interventions so that they contribute to the national and State governments' priorities. The resource pooling mechanism for

RCH was satisfactory. The system Development partners' forum worked well. MoHFW encouraged DPs to participate in the JRMs and CRMs.

- Two prong approaches was adopted by the Development Partners to support the RCH programme. The World Bank, DFID, and UNFPA pooled their resources to reimburse the eligible expenditure. Whereas other DPs such as European Commission, USAID, UNICEF, WHO, NIPI and JICA provided their financial and technical assistance from outside the pool.

- Overall World Bank's performance during the RCH-II programme period was satisfactory. The Bank's allocation for SDR 245 million was fully utilized. However, the disbursement was slow in the beginning due to stringent fiduciary systems of World Bank.

- During RCH-II the traditional advisory and programme support role of the World Bank was sub-optimal and the Bank's role was predominantly that of a lending institution. Stringent conditionalities imposed by the Bank, were sometimes, an impediment to speedy and effective programme implementation.

- There have been some categories under the Development Credit Agreement such as "consultant services, training" where fund utilization was 'nil'. More effective implementation of this category would have resulted in system strengthening and capacity building in the MoHFW.

KEY ISSUES AND LESSONS LEARNT

9. Key issues and lessons learnt include :

- Different aspects of RCH were under different administrative heads for different periods during the programme especially family planning. A single administrative head for RCH and improved coordination across cross cutting functions (IEC, M&E, and procurement etc.) has the potential to provide better results.

- In many states, the use of HMIS data or data from surveys needs to be strengthened for the preparation of district health action plans and for monitoring at PHC, block, and facility level.

- There is lack of integration of MCTS with HMIS; there is also lack of consistency in recording formats within the state and between the states.

- Tenure and stability of persons holding key posts under NRHM has been an issue across many states.

- Though the number of contractual staff has increased sharply, their productivity and morale could be better. Key underlying factors include: delay in renewal of contracts, poor service conditions and increments, ineffective appraisal system, reluctance to nominate them for longer skill based training, and a wide distinction between contractual and regular staff performing the same tasks. Strengthening of HRD aspects is a must.

- The management of training across states needs further improvement. Comprehensive Training Plans (CTPs) submitted by states are typically prepared in isolation and not aligned with the infrastructure up gradation and the HR plans resulting in highly trained resources (MOs trained in LSAS and CEmOC) being confined to facilities where they are not in a position to practice their skills. Database of trained staff is typically not available. Moreover, training needs across all programs are not harmonised.

- The NPIP envisaged that for the initial two years, the MOHFW – through the Empowered Procurement Wing (EPW) would take responsibility for procurement of drugs, vaccines, equipment, kits and contraceptives and for the subsequent years, the states would gradually take over such procurement following the "Governance and Accountability Action Plan" (GAAP) as set out in the NPIP. However, central procurement was remained delayed throughout the project period. Further, there was slow progress on strengthening of state capacities for procurement as a precursor to decentralisation.

- Although Gender Mainstreaming was a key strategy in RCH II design, it was understood variably and was implemented as a set of dispersed activities.

SUSTAINABILITY

10. A number of RCH structures and processes are already embedded in the system and these augur well for sustainability. These include:

- Focus on outcomes
- Flexibility to states in application of funds
- Increased emphasis in terms of funds and attention to districts/ blocks with poor health indicators
- State and district program management units; increased capacity at central level

- Preparation of state PIPs based on District Health Action Plans (DHAPs); subsequent appraisal through National Programme Coordination (NPCC) meetings
- Monitoring of progress through review meetings and quarterly variance analysis reports
- Web based HMIS
- Financial reporting system; electronic transfer of funds; concurrent audit
- State are increasingly absorbing contractual human resources into the state cadre

Borrower's Comments on Draft ICR

Comments on Implementation Completion and Result Report (ICR) for RCH-II project

Result framework analysis: under PDO indicators-indicator no. 5

In the ICR it has mentioned that "India has been certified by WHO as having achieved polio-free status as on Jan 2012".

The above sentence may be replaced to "WHO has removed India from the list of countries with active endemic wild poliovirus transmission on 24th February 2012."

Under Intermediate Indicator(s) - Indicator 6: % of districts (in EAG states + Assam) on having the following:

(i) District Hospital conducting at least 20 C-sections in a quarter

In the ICR, actual value achieved regarding the above indicator is 50%. However, based on review of the reports obtained from the State on performance of Delivery points most of the DHs excluding few conducts > 50 deliveries per month. 274 DHs out of 305 Districts in EAG states and Assam are conducting C-sections. Seeing the case load, all 274 DHs are conducting more than 20 C-sections per Qtr or 6-7 C-sections per month, i.e. **89%** of the districts are having DHs conducting at-least 20 CS per QTR. In view of above actual value achieved may be corrected.

(ii) At-least one sub-district hospital conducting 10 C-section in a quarter

In the ICR, actual value achieved regarding the above indicator is 40%. However, based on review of the Delivery Point reports, out of 305 districts, there are nearly 230 districts which have at-least 1 SDH/ FRU level hospital below district level conducting C-sections. All these 230 districts have at-least 1 SDH/ CHC/ FRU conducting > 3 - 4 C-sections per month or 10 C-sections per QTR. So % of districts where at-least 1 sub-district hospital / CHC/ FRU conducting at-least 10 C-section per quarter is **75%.** In view of above actual value achieved may be corrected.

Page 16: Achievement of Project Development Objectives

The Annual Health Survey results can be considered, under 3.2 Achievement of Project Development Objectives. AHS data is of a later period than the CES 2009 referred as the endpoint data.

Page 12: Procurement

It is stated that RCH Kit-A and RCH Kit-B were procured in Kit form and all other Kits were procured as individual drugs. In case of Kit-A and Kit-B, the World Bank suggested to procure one third quantity in Kit form and the balance as individual drugs to be kitted by an independent Kitting Agent. The latter mode did not fructify because of poor response to RFP for hiring Kitting Agent. In view of above it may not be correct to say that "kitting agent" approach was not tried.

It is stated that the storage facilities are expected to improve as MoHFW has registered Central Medical Services Society for carrying out procurement under Central Healthcare Schemes and the constraints on account of storage space will be addressed as it plans to set up 40 warehouses across the country.

In view of above, the content of the relevant paras may be corrected

Page 17:

As per CES 2009, the overall coverage of full Immunization is 61% instead of 5401%, may be corrected

Page 21: Overall trends in maternal and child health outcomes during the project period

"Under-five mortality (U5MR) has stayed about the same from 60 per 1,000 live births in 2008 to 59 per 1,000 live births in 2010"

The above need to be corrected as: U5MR has declined from 69 per 1000 live births in 2008 to 59 per 1000 live births in 2010 thus showing consistent decline of 5 points per year over 2 consecutive years.

Page 26: Socio-cultural barriers to health seeking behaviour

Community participation in health system strengthening as suggested under NRHM is another dimension that would reduce the Socio-cultural barriers to health seeking behaviour in addition to the suggestions made on Page 26, the above can be added in the ICR

Page 30-31: Overall implementing agency performance: Moderately Satisfactory

Considering the size of RCH-II project in the given decentralized settings and based on the overall performance, systems strengthened and the expenditure incurred on the project, this Ministry rate the overall implementation of the RCH project **satisfactory** instead of **moderately satisfactory**.

Page – 31

It has mentioned at p.31 in the first para of ICR that the greatest weakness remains the delay in release of the DLHS 4 survey data that would have provided more definitive information on project achievements until 2010, close to the endline of the project.

This Ministry may not agree to the above statement, Annual Health Survey, conducted in EAG states and Assam, results have been published that can be considered to assess the impact of the project.

Page 36: Janani Shishu Suraksha Karyakram (JSSK)

JSSK seeks to finance facilities based on a standard costing of agreed inputs to ensure free and cashless deliveries;

This sentence may be corrected as

"JSSK seeks to finance facilities based on a standard costing of agreed inputs to ensure free and cashless deliveries and free treatment and free transport of newborns for first thirty days of life.

Annex 8. Comments of Cofinanciers and Other Partners/Stakeholders

Comments from DfiD, India:

The issue of the correlation between RCH expenditure and institutional delivery is a complex one, the confounder being that institutional delivery drives a large part of expenditure on maternal health in the form of the JSY transfer, so it could equally be that increasing institutional delivery has driven expenditure. This is an important dynamic to bear in mind since improved quality of obstetric services will depend on increased expenditure for other aspects of maternal care, which has been slower to take off than the JSY payment.

One of the key learnings from the programme for DFID has been that increasing demand (e.g. for maternal health services) does not necessarily drive increased quality and separate efforts need to go into quality improvements. The programme as a whole is still identifying the most effective means of generating sustained quality improvements, although a lot of approaches are being trialled (accreditation, third party review, self derived quality improvement at clinic level, team based training and review).

On gender issues, it is worth pointing out that a specific gender review was conducted for the midterm review of the programme which focused not just on gender equity within health services consumption, but also the issue of sex selective abortion, and implementation of the Indian PCPNDT Act. The review (and previous JRMs) outlined a number of recommendations on improving states approach to sex selective abortion, many of which states have begun to implement.

I like the reflection on the handling of the post-DIR period in the report, which I think is balanced. As a pooling partner we were conscious that sensitivities about the DIR and the way it was released led to a weakening of our policy dialogue for some time. I wonder why these issues don't appear in the learnings section of the report in terms of the role of the DPs. Your points that the procurement and financial discussions crowded out other aspects of the technical discussion is important, and future programmes must find a way to preserve both.

Finally I would have given the Bank a higher performance rating for its implementation support on programme management and financial management. I think the constant pressure to the FMG to get information up from the states has helped improve the flow of financial information and to underpin the role of FMG in driving financial management improvements. Still a job half done but nonetheless one to which the Bank has contributed significantly.

Comments from UNFPA, India:

The report is well written and captures most of what one wants to consider for such a review. Therefore we have very few observations and suggestions:
1.Though reference is made to gender issues that have been addressed in the project, in

the later part of the document (3.5a), it may pertinent to refer to the inclusion of Gender as a separate area of assessment in the MTR. This was for the first time that Gender was included for assessment in the health sector in the country and this also set the trend for this to be continued in the CRMs.

2. In the recommendations, though governance has been referred as an area that needs improvement, the author could consider if she would like to refer to the need for improvements in programme management at the District level, which is the basic unit of planning and implementation of RCH programmes in the country. The report comments on the lack of capacities for programme management in the body of the document but stops at making it a point in the recommendations.

3. The other aspect that could be useful to highlight in the lessons learnt is the need to focus on quality improvement, meaning to move the focus from monitoring inputs to processes resulting in improved quality of services. May be I am wrong, but I did not find reference to the MIS strategy of RCH II which emphasised on quality as one of the prongs of the MIS strategy (there is reference to triangulation of data in the report). The author could consider the QA aspect as well.

As stated at the outset, the report is well written and hope the Govt finds it useful.

Annex 9. List of Supporting Documents

List of documents / reports referred to in the ICR:

a) DLHS-3 and DLHS 4 survey report.
b) RCH II Mid Term Review Aide Memoire
c) RCH II Restructuring Paper; May2010.
d) **RCH II** Implementation Status Reviews Reports
e) Registrar General of India: Report of the Sample Registration System on MMR; 2009.
f) Registrar General of India; Sample Registration Survey, 2010.
g) DHS Final Report, India 2005-06
h) Mid-Term Review: Thematic Report on Programme Management and Monitoring; Progress (2005-08),
i) Key Issues and Way Forward; Donor Coordination Division, MOHFW; March 2009
j) Paul VK et al. Reproductive Health, and Child Health and Nutrition in India: Meeting the Challenge. India: Towards Universal Health Coverage 2; The Lancet; January 2011.
k) Vikram Rajan, VK Manchanda and S Nagarajan. Quality of Obstetric Care in India: will we 'deliver' on time? Public Health Foundation of India;
l) SRS 2010
m) UNICEF Coverage Evaluation survey (CES-2009)
n) UN Population Division; World Population Prospects
o) NFHS-3 data were used for institutional deliveries 2005-06; and MIS and census 2011 data were used for institutional delivery rates for 2010-11

List of Tables and Figures: