Program Implementation Document

Project Number: 47354-003
March 2015

Proposed Results-Based Loan and Administration of Technical Assistance Grant
India: Supporting National Urban Health Mission

CONTENTS

ANNEXES

PURPOSE OF THE PROGRAM IMPLEMENTATION DOCUMENT

The developing member country (DMC) is wholly responsible for implementing the program supported by results-based lending (RBL). The Asian Development Bank (ADB) staff support the results based lending program design and implementation.

The program implementation document (PID) consolidates the essential program implementation information. The PID is a management tool which supports effective program implementation, monitoring, and reporting. It is developed throughout the program processing, and should be discussed with the DMC at Loan Negotiations. It is a living document that should be refined and kept up to date during program implementation.

Abbreviations

ADB	=	Asian Development Bank
ANM	=	auxiliary nurse midwife
ASHA	=	accredited social health activist
BMW	=	Biomedical waste
CPMU	=	city program management unit
CRM	=	common review mission
DLIs	=	disbursement-linked indicators
DMC	=	developing member country
DPMU	=	district program management unit
EMP	=	environmental management plan
FMG	=	financial management group
FY	=	fiscal year
HMIS	=	health management information system
IEE	=	initial environment examination
IMEP	=	Infection Management and Environment Plan
IT	=	information technology
JSY	=	Janani Suraksha Yojana
M&E	=	monitoring and evaluation
MAS	=	Mahila Arogya Samitis
MIS	=	management information system
MOHFW	=	Ministry of Health and Family Welfare
NFHS	=	National Family Health Survey
NHAM	=	National Health Assurance Mission
NRHM	=	National Rural Health Mission
NUHM	=	National Urban Health Mission
PAP	=	program action plan
PFM	=	public financial management
PID	=	program implementation document
PIP	=	program implementation plan
PMU	=	program management unit
PPP	=	public-private partnership
RBL	=	results-based lending
RRP	=	report and recommendation of the president
SBM	=	Swachh Bharat Mission
SPMU	=	state program management unit
TA	=	technical assistance
TOR	=	terms of reference
UCHC	=	urban community health center
UHC	=	universal health coverage
ULB	=	urban local body
UPHC	=	urban primary health center
UT	=	union territory

I. PROGRAM DESCRIPTION

1. India has made good progress in achieving health outcomes over the last decades, but the urban poor have largely been left behind. Alongside rapid urbanization, the urban poor, estimated to be around 77.5 million, are one of the fastest growing and most vulnerable population segments in India. They face harsh living conditions and have limited access to basic health care, resulting in their disproportionate burden of ill health. For example, the under-five mortality rate among urban poor was 72.7 per 1,000 live births compared to the urban average of 51.9.[1] The majority of urban poor women delivered their babies at home.[2] Almost 60% of the urban poor children below one year of age missed total immunization, compared to urban average of 42.4%.[3] Many are also migrant workers with informal status, which limits their access to basic public services and welfare programs.

2. The delivery of health services in urban areas is fragmented with weak referral linkages. Past interventions have tended to be vertical programs focusing on particular diseases, rather than investments made to strengthen broader urban health systems. Urban primary health facilities are limited in number, underutilized, vary in norms and quality, and have limited scope of services, including community outreach and health promotion. The major proportion of curative primary care occurs at secondary and tertiary levels, leading to inefficiencies and overcrowding of these centers. Financial protection for the poor and near-poor is a key concern, given that a major part of total health expenditures is paid out-of-pocket to private providers, which can lead to their further impoverishment.

3. Private health providers are dominant in urban areas, but the large number of urban poor cannot afford the services. The private health sector's contribution to primary health care has also been minimal. The enabling environment for private sector engagement is limited in the health sector, due to inadequate regulatory mechanisms and management capacity. Moreover, health in the urban context is affected by multiple determinants in the physical and social environment and access to health services. For example, diarrhea—a leading cause of death among children in India—is clearly correlated with poor water, sanitation, and hygiene behaviors. More attention is therefore required to promote integrated urban planning and convergence across key sectors affecting urban health.

4. As a policy response, in May 2013, the Government of India launched the National Urban Health Mission (NUHM) to strengthen health service delivery in urban areas. The NUHM builds on extensive stakeholders' consultations and successful experience of the National Rural Health Mission (NRHM), which started in 2005. The NUHM and the NRHM form the National Heath Mission (NHM) as Sub-Missions under the Government's Twelfth Five–Year Plan. As a core strategy, NUHM will enhance the public health system infrastructure through establishing a network of urban primary health centers (UPHCs) covering all cities and large towns. The UPHCs will be linked with community outreach and referral services and will expand urban population's access to health services and strengthen primary health care in urban areas. Given that urban health is a developing field and a new priority area for the Government of India, NUHM requires strong support at all levels to gain critical momentum and to effectively tackle evolving challenges unique to the urban context. In October 2014, the Government of India also introduced the Clean India Initiative, or *Swachh Bharat Mission* (SBM), to provide universal access to sanitation facilities in urban areas. Ensuring coherence and convergence of the

[1] Ministry of Health and Family Welfare. 2007. *National Family Health Survey (NFHS-3), 2005–2006*. New Delhi. The next survey, NFHS-4, 2014−2015 is due in 2016.
[2] Ibid.
[3] Ibid.

NUHM and SBM will be crucial to attain the desired health outcomes. Building on the gains of the NHM, the Government of India plans to progressively move towards universal health coverage (UHC) under the Twelfth Five–Year Plan. Success of the NUHM will be critical to the UHC agenda in urban areas, as UPHCs are expected to play a gatekeeping role in referrals and insurance coverage for the urban poor.

5. The Supporting National Urban Health Mission (the program) will support NUHM implementation by strengthening institutions and management capacity. The key features include (i) strengthening management and implementation processes (including monitoring and evaluation [M&E]) through significant capacity building; (ii) convergence between health and urban sector interventions, emphasizing integrated city-level planning with active involvement of urban local bodies (ULBs); (iii) partnerships and mechanisms to engage the private health sector, including not-for-profit entities; (iv) community participation to enhance governance and delivery of health services; and (v) learning and sharing knowledge, good practices, and innovations in urban health. The program draws significant value addition from Asian Development Bank (ADB)'s extensive experience in the urban sector and public-private partnership (PPP) advisory services in India.[4]

6. The NUHM aims to improve the health status of the urban poor by facilitating equitable access to quality essential health services. The program will reinforce the NUHM's efforts by prioritizing selected results and sequencing the targets critical to achievement of NUHM outcome. More specifically, the program results emphasize effective service delivery through quality assurance, reaching the poor and the vulnerable, enhancing private sector participation and inter-sectoral convergence, knowledge and innovation, and improved management capacity and business processes.

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Table 1: Program Scope

Item	National Urban Health Mission[a]	Program
Outcome	Equitable access to quality health care	Same as NUHM
Key outputs (NUHM core strategies)	(i) Improve efficiency of public health systems in cities (ii) Promote access to improved health care at household level (iii) Strengthen public health thrust (iv) Increase access to healthcare and address out-of-pocket expenditure (v) Improve health access, surveillance and monitoring through ITES and e-governance (vi) Build capacity of stakeholders (vii) Prioritize most vulnerable among	Same as NUHM, organized into three outputs: (i) Urban primary health care delivery system strengthened (ii) Quality of urban health services improved (iii) Capacity for planning, management, and innovation and knowledge sharing strengthened

[4] ADB has nearly two decades of experience in the urban sector in India, currently covering 17 states. It is also implementing the long-term Initiative for Mainstreaming PPPs in India through the Department of Economic Affairs.

Item	National Urban Health Mission[a]	Program
	poor (viii) Ensure quality of healthcare services	
Program expenditure	$3,751 million	$1,955 million[d]
Main financiers	Government of India[b]	Government of India (84.4%) Asian Development Bank (15.6%)
Geographic coverage	Nationwide	Same as NUHM
Implementation period	2013–2017[c]	2015–2017

ITES = information technology-enabled services, NUHM = National Urban Health Mission.
[a] Government of India. 2013. *National Urban Health Mission, Framework for Implementation.* New Delhi.
[b] Including shares of state governments
[c] The Cabinet approved NUHM in May 2013, and implementation commenced in 2014.
[d] Sum of FY2015 and FY2016 projections approved by EFC and the revised budget for FY2014.
Source: Ministry of Health and Family Welfare and Asian Development Bank.

II. RESULTS AND DISBURSEMENT

A. Program Results

8. The impact of the program will be improved health of the urban population, particularly the poor and the vulnerable, across India. The program results framework is in Annex 1. The outcome will be increased access to equitable and quality urban health system, as evidenced by increased institutional deliveries (disbursement-linked indicator [DLI] 1) and complete childhood immunization (DLI 2). Increased institutional deliveries, with their quality assured, will help reduce deaths among mothers and newborns at the impact level. Improved immunization coverage will also help avert infant and child mortality. These indicators were chosen as they reflect high levels of inequity between urban poor and non-poor. The outcome will be achieved through the following outputs:

9. **Output 1: Urban primary health care delivery system strengthened.** NUHM aims to establish a system of urban primary health facilities covering cities and large towns. This output will sharpen the focus of NUHM investments on the urban poor through support for mapping of slums and vulnerable population and city-level health planning with active involvement of ULBs (DLI 3, Program Action Plan [PAP] 1.4 and 1.5). This will allow NUHM to have greater synergy with other urban services for improving health outcomes, especially for the urban poor. This output will also ensure that minimum requirements (e.g., critical inputs [staff, medicine, equipment] and service package, including referral services based on mapping using geographic information system) are met at the urban primary health centers (DLI 3). NUHM aims at strengthening community outreach services to extend community health awareness and demand for services through the urban accredited social health activists (ASHAs) and *Mahila Arogya Samitis* (MAS) (community collectives comprising local women). This output will ensure timely recruitment and adequate training of urban ASHAs, and close monitoring of their functioning and effectiveness (DLI 4). It will also undertake operational research and capacity building of community-based institutions such as MAS (PAP 1.2).

10. **Output 2: Quality of urban health services improved.** NUHM will introduce a quality assurance mechanism for urban primary health facilities in a phased manner. This output will ensure that (i) organizational arrangements for quality assurance and capacity to manage the

quality assurance system are established at state level; (ii) quality measurements include client-satisfaction; and (iii) the NUHM monitors the progress and evaluates effectiveness of the quality assurance mechanism to guide states for further quality improvements (DLI 5 and PAP 1.7). The output will also review existing private provider regulation, accreditation practices, and incentives for improving quality, accountability, and reliability of services to promote an enabling environment for private health sector engagement (PAP 1.3 and 1.6).

11. **Output 3: Capacity for planning, management, and innovation and knowledge sharing strengthened.** NUHM needs significant capacity in program management and technical aspects of urban health to operationalize the NUHM implementation framework effectively. This output will enhance staff capacity to implement NUHM (DLI 6, [i] for prior result and 2016 and [iii] for 2015). This output will help the NUHM develop and implement a capacity development framework to plan, monitor, and incentivize capacity development for urban health (DLI 6, [i] for 2015).[5] States with weak capacity will be prioritized for capacity development support. This output will enhance the existing M&E mechanisms and staff capacity to better support NUHM operations, progress monitoring, and feedback to policy and planning. More specifically, it will (i) improve the existing health management information system to produce urban disaggregated data (DLI 6, [ii] for 2015); (ii) strengthen existing management information systems to monitor NUHM progress; and (iii) improve data on key health outcome indicators (PAP 1.1 and PAP 5). This output will also assist Ministry of Health and Family Welfare (MOHFW) to develop and implement a framework for innovations and partnerships (DLI 7). The framework will systematically capture the home-grown innovations and lessons, adapt international best practices, promote cross learning for replication and scale-up, and incentivize more innovative approaches and partnerships.

12. **Convergence and PPP**. The program will promote convergence and PPP across the three above outputs. Convergence will be strengthened at three levels: (i) policy and planning at state level, where state health societies include representatives from health and urban departments, (ii) integrated planning for urban health at city level with active involvement of ULBs, including in planning and mapping of slums and vulnerable populations, and (iii) community level processes and participation for better urban services (e.g., water, sanitation, housing, and health services) and improved health and hygiene practices. The program will also strengthen the enabling environment and capacity for private sector engagement through (i) conducting detailed assessment of experience, challenges, and opportunities for PPPs in India's health sector, and (ii) developing policy guidelines and menu of models and options for PPPs in urban health, including with the not-for-profit sector.

B. Disbursement-Linked Indicators and Disbursement Allocation

13. The DLIs represent a sub-set of overall program results, prioritized and sequenced to contribute to NUHM progress towards outcome. Achievement of the annualized DLI targets will trigger loan disbursement in pre-agreed amounts. Those that are important for outcome

[5] The framework will include (i) comprehensive human resource development plan for managerial and technical personnel; (ii) strengthening of existing national and state entities to support urban health, (iii) provision of technical and management support to MOHFW and states - especially lagging ones, through a pool of experts and demand-based consulting inputs through indefinite service delivery contract, and (iv) enhancing knowledge, training, and institutional capacity in urban health through organization of international and national forums, twinning arrangements between schools of public health in India and abroad, and a new dedicated institute for urban health research and training.

achievement but difficult to link to disbursement are included in the PAP.[6] The DLI matrix and the disbursement allocation are in Annex 2 (Table A1 and A3).

C. Disbursement Linked Indicator Verification Protocols

14. The DLI verification protocol is in Annex 2 (Table A2). A rigorous verification protocol, including independent, third-party validation, has been established. Verification of outcome DLIs will rely on the Health Management Information System (HMIS), validated by independent consultants for data quality and triangulated with population-based survey data to verify overall trends. Output DLIs will be verified through (i) sample-based joint reviews by MOHFW and ADB after reports from the states are received to gain better insights from implementation of program activities at the state level, and (ii) using existing database and comparing it with expenditure reports.[7] Independent evaluation of effectiveness and progress in quality assurance and capacity development framework will be used for DLI verification as well as target setting for subsequent years. The verification process is designed to strengthen MOHFW's capacity in overseeing and supporting the state-level implementation of NUHM activities.

D. Disbursement Arrangements

15. The loan will be disbursed over 3 years, subject to the achievement and verification of the DLIs. The initial disbursement, up to $40 million, will be disbursed after loan effectiveness and upon verification of achievement of prior results which are completed within 12 months before the loan effectiveness. These prior results include (i) state-level NUHM implementation plans approved in FY2015, (ii) urban-specific guidelines for community health workers and quality assurance; and (iii) adequate staffing for states, districts, and cities. All prior results are already met as of December 2014 or at an advanced state. The subsequent disbursements will be made annually after the corresponding DLIs are met. Partial disbursement is allowed for DLIs 1 and 2 as per the verification protocol.

16. ADB will field periodic review missions, including validating DLI achievements, preceding the submission of withdrawal applications. Once DLI achievements are validated, MOHFW will submit withdrawal applications, together with the DLI achievement report to ADB. Any amount not disbursed for unmet DLIs will be disbursed once the DLIs are achieved. The loan proceeds will be disbursed to the government's consolidated fund. ADB disburses directly to one of the government's central revenue accounts (Deposit Account) [at Reserve Bank of India]. The funds from the consolidated fund are released in accordance with government procedures.

17. ADB will review the cumulative sum of eligible expenditures to confirm that the government's eligible expenditures exceed the amount disbursed by ADB, using audited financial statements, supplemented by certification of the Financial Management Group (FMG) of MOHFW once they become available every year.

E. Eligible Expenditures

18. As per the ADB's Policy on RBL, procurement involving high-value contracts, where the value equivalent or more per contract the amounts specified below (as amended from time to time as per the RBL policy and the staff guidance note), will be excluded:[8]

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[6] PAP also includes actions to improve country systems in financial management, procurement, safeguards, M&E and gender and social equity areas.

[7] The accompanying TA will support independent verification of DLIs and strengthen the existing HMIS, ASHA MIS and Program Management Unit MIS, etc. to ensure timely and credible data collection.

[8] ADB. 2014. *Staff guidance for RBL, footnote 14.*

(i) $50 million for works, turnkey and supply and installation contract
(ii) $30 million for goods
(iii) $20 million for IT systems and non-consulting services
(iv) $15 million for consulting services

19. The program will also exclude (i) procurement from any non-ADB member country; and (ii) any contracts awarded under the small and medium enterprise preference scheme of Government of India.

20. Following the Guidelines to Prevent or Mitigate Fraud, Corruption, and Other Prohibited Activities in Results-Based Lending for Programs (Appendix 7 to the RBL policy), city program management units (CPMUs) and state-level state program management units (SPMUs) will be given user ID and passwords to the ADB's Anti-corruption Sanction List in order to ensure that they do not award any contract to the sanctioned entities. It will be further reviewed and confirmed during annual procurement review in the five states every year.

21. ADB funds under the program will not be applied to the activities described in the ADB prohibited Investment Activities List set forth at Appendix 5 of the Safeguard Policy Statement (SPS). The government will ensure that their investments are in compliance with applicable national laws and regulations and will apply the prohibited investment activities list to activities in the program supported by ADB funds.

22. Any civil work activities that trigger involuntary resettlement and indigenous peoples issues will be deemed as ineligible expenditure for the ADB financing, therefore, deducted from the total eligible expenditures.

23. FMG under MOHFW, based on the audited financial statements from the states, will certify that the total NUHM expenditures minus the following ineligible items are equal or more than ADB financing:

(i) high value contracts as per the RBL policy
(ii) contracts procured from non-ADB member countries
(iii) any contracts that are awarded under the small and medium enterprise preference scheme of Government of India[9]
(iv) any contracts that are awarded to ADB-sanctioned entities
(v) any activities described in the prohibited investment activities as per ADB's SPS
(vi) any civil work activities that trigger involuntary resettlement and indigenous peoples issues as per ADB's SPS

24. FMG's certification can be based on FMG's assessment of eligible expenditures at least equal or exceeding ADB financing based on the review of the audited financial statements from states covered by the program. FMG's certification will be on annual basis, at the time of audit report submission.

[9] The proportion of the procurement affected with SME preference will be a small portion and therefore, majority of the program will be without any price preference. As ADB is financing less than 12% of total program expenditures, it is reasonable to say that ADB financing is deemed to cover contracts that are not using SME preference.

III. EXPENDITURE FRAMEWORK AND FINANCING

A. Expenditure Framework

25. The program will support NUHM expenditures, which are estimated to be $1,954.9 million from FY2014 to FY2016 (Table 2).

Table 2: Summary of Program Expenditure Framework (FY2014–FY2016)
(in 2014 prices)

Item	**Amount** ($ million)	**Share of Total** (%)
Recurrent	**1,535.4**	**78.5**
Strengthening health services (operation)	1,049.9	53.7
Community processes	135.1	6.9
Regulation and quality assurance	20.0	1.0
Training and capacity building	74.8	3.8
Innovative actions and PPP	91.9	4.7
Program management, planning and mapping, M&E	163.7	8.4
Capital	**419.5**	**21.5**
Strengthening health services (civil work and equipment)	419.5	21.5
Total	**1,954.9**	**100.0**

M&E = monitoring and evaluation, PPP = public-private partnership.
Sources: Asian Development Bank estimates based on Government of India, Ministry of Health and Family Welfare. 2012. *National Urban Health Mission – EFC Note with Annexures, 16 August, p. 12*; Delhi; Government of India, Ministry of Finance. 2014. *Union Budget – Notes on Demands for Grants, 2014–2015, No. 46/Department of Health and Family Welfare;* and information provided by Financial Management Group of NHM, MOHFW.

B. Program Financing

26. The total financing needs of the NUHM for the period FY2014–FY2016 are estimated at $1,954.9 million, of which the government has requested a loan of $300 million from ADB's ordinary capital resources to finance the program. The loan terms and conditions are in the loan agreement.[10] Subject to review of implementation progress, the government may further request an additional financing of $200 million in 2017 to support NUHM's transition and continuation into the next Five−Year Plan. The financing plan for the program is summarized in Table 3.

Table 3: Program Financing Plan (FY2014–FY2016)

	Amount ($ million)	**Share of Total** (%)
Government of India	1,654.9	84.7
Asian Development Bank		
Ordinary capital resources (loan)	300.0	15.3
Total	**1,954.9**	**100.0**

Source: Asian Development Bank estimates.

IV. PROGRAM SYSTEMS AND IMPLEMENTATION ARRANGEMENTS

27. **Implementation Arrangements**. Program implementation will follow the NUHM Implementation Framework. MOHFW will be the executing agency. The National Health Mission Steering Group under the Union Health Minister, the Empowered Program Committee under the

[10] The interest includes a maturity premium of 10 basis points. This is based on the loan terms and the government's choice of repayment option and dates.

Secretary of MOHFW, and the National Program Coordination Committee under the Mission Director will guide and oversee NUHM implementation, including the program. The Urban Health Division of MOHFW will be the implementing agency, coordinating program activities and supporting the activities at state level. The states will prepare periodic reports on progress towards DLIs and PAP, as part of their regular reporting on overall NUHM implementation. MOHFW will consolidate state level reports and submit periodic progress reports on achievements of DLIs and PAP and other NUHM key performance indicators and prepare DLI achievements report for disbursement purposes.

A. Monitoring and Evaluation System

1. Summary of Monitoring and Evaluation System

28. The M&E system assessment found that NUHM's central monitoring framework comprising oversight and steering committees, various MIS', and annual joint review missions is robust enough for tracking the program's outputs and outcome.[11] The areas for further strengthening include (i) enhancing existing systems to track information specific to NUHM progress and main program beneficiaries (urban poor and vulnerable groups); (ii) building capacity of data entry operators and MIS officers at all levels; (iii) harmonizing operability of multiple systems; and (iv) providing adequate resources to improve coverage and accuracy of reporting and availability of quality and timely data. MOHFW will be responsible for performance monitoring against a set of key performance indicators that are defined within both the NUHM implementation and results frameworks, including DLIs and PAP targets. MOHFW will also draw on interagency information systems to obtain urban health-related results indicators for preparing annual performance reports.

2. Monitoring and Evaluation System Related Actions

28. The program will help strengthen NUHM M&E systems for evidence-based planning through capacity building to improve data quality, coordination, and translation of urban health information. The program will also incentivize innovations that enhance the way health information is collected, processed, and analyzed.

29. **Data quality.** In order to accurately measure achievement of NUHM, facilities in urban areas serving population over 50,000 will be identified and disaggregated as "urban" in the HMIS (DLI 6). Strengthening M&E system is included as a key area for capacity development in DLI, including (i) adapting NRHM MIS format for NUHM; (ii) expanding reporting of HMIS by facilities; (iii) training data entry operators and data administrators in data quality; and (iv) community processes data collected under ASHA MIS.

30. **Coordination.** ADB and MOHFW will jointly monitor the implementation of the program through regular review missions, including annual fiduciary reviews, which include a procurement performance review carried out by an independent entity. The annual review will assess and verify the achievement of program targets and DLIs, which form the basis for fund disbursements. The program will also build on Annual Common Review Missions (CRMs) and periodic Joint Review Missions under NHM to substantively review NUHM and urban health issues with recommendations and action plans to traverse gaps. The program will also support NUHM to build on existing information collection gathering processes, such as of the National

[11] Program M&E System Assessment (accessible from the list of linked documents in Appendix 2).

Malaria Control Program, Revised National Tuberculosis Control Program, etc., to inform indicators in the NUHM Implementation Framework.

31. **Analyses of urban health information.** Periodic surveys (National Family Health Survey [NFHS], Sample Registration System, National Sample Survey Office) will be used to analyze key urban health outcomes, such as maternal and child mortality, prevalence of communicable disease (e.g. diarrhea), and for comparing trends in DLI outcome achievement. NFHS, 2014–2015 (available in 2016–2017) will be able to provide disaggregated measurements for urban and rural, as well as by wealth status. Under the capacity development component, there is also scope to conduct selected rigorous impact evaluations, operations research, and case studies in select states and cities to examine issues for urban health such as: (i) community processes; (ii) health seeking behavior; (iii) PPPs; (iv) private sector regulation for health service delivery; (v) the direct effect of NUHM on health status; (vi) cost-effectiveness and efficiency of NUHM; (vii) various innovations and components (information and communication technology, community mobilization, behavior change and communication, etc.); and (viii) out-of-pocket health care expenditures. The studies and evaluations would contribute to urban health knowledge base and program research.

32. **Incentivizing innovations.** The program will also support central/states/ULBs in innovative approaches for progressively improving and meeting the emerging needs of NUHM M&E (DLI 7). Actions to incrementally improve M&E include the following: (i) HMIS indicators capture information on equity and reaching of poor and vulnerable groups; (ii) HMIS captures information on unique users of services, i.e., urban or rural residence, male or female, age, etc. towards accurate reporting, attribution of results, and avoids double-counting; (iii) includes an HMIS module on community outreach, at the state and/or central levels, to encompass monitoring of performance on activities and functions of ASHAs, link workers, link health volunteers, community health workers, and auxiliary nurse midwives who conduct outreach; (iv) harmonize all existing data (HMIS, Mother and Child Tracking System, ASHA MIS, Geographic Information System, etc.) into a one-stop data platform for district level planning; (v) use of mobile and technological devices; (vi) post trained data entry operators in every facility to improve HMIS coverage; (vii) enhancement of the web-based HMIS for data entry at all levels to address problems of quality and timeliness; and (viii) develop mechanism to incentivize private facilities to upload data to the HMIS.

33. The following are the key M&E program actions as included in the PAP in section VI.

(i) Review and strengthen HMIS and MIS indicators to adequately capture key processes and outcomes related to urban health and NUHM implementation framework (e.g. referrals, diarrhea);
(ii) Include quality assurance module in HMIS formats to reflect quality aspects of health services delivery, as per Quality Assurance Guidelines, 2013.
(iii) CRM reports of NHM will substantively review NUHM and urban health issues with recommendations and action plans to traverse gaps, if any; and
(iv) (i) Develop NUHM MIS, by adapting existing NRHM MIS formats, to meet NUHM program reporting requirements, including on key indicators, components, and processes; (ii) generate NUHM program quarterly and annual progress reports.

34. Within 12 months of loan closing of the program, MOHFW will produce a program completion report which will be shared with ADB.

B. Fiduciary Systems

35. Rigorous financial management, procurement and anti-corruption systems assessments confirm the program systems are adequate for RBL with some risk mitigation measures.[12] The overall financial management risk is moderate. Areas for improvement include (i) adequate human resources trained for accounting and internal control, especially at some states and sub-state entities, and (ii) timely financial reporting and auditing. The PAP includes risk mitigating measures in (i) enhancing fiduciary performance monitoring, (ii) supporting staff capacity development, (iii) ADB's participation in annual common review missions of MOHFW's financial management group, and (iv) the provision of program financial statements following a Statement of Audit Needs.

1. Financial Management System

a. Summary of Financial Management System

36. The overall financial management risk is moderate. The role of the FMG under MOHFW has been extended to cover overall financial management of the NUHM in addition to that of the NRHM. FMG achieved significant progress in strengthening accounting procedures and internal control of the NRHM since 2006, and NUHM implementation will benefit from that, too. FMG is currently implementing incremental enhancements including (i) development of training and recruitment plan; (ii) ongoing annual monitoring review missions; and (iii) integration of fund monitoring and on-line payment system with MOHFW accounting system. Under the program, the NUHM through FMG will ensure (i) adequate human resources trained for accounting and internal control, especially at some states and sub-state entities, and (ii) timely financial reporting and auditing. FMG's role needs to be further strengthened to improve state and sub-state level financial management through FMG's systematic monitoring and feedback.

b. Financial Management System-Related Program Actions

37. The following are the key financial management system-related program actions as included in the PAP in section VI:

(i) Submit annual audited financial statement in accordance with detailed statement of audit needs.[13]
(ii) Develop detailed fund flow mechanism for cities and districts after consideration of individual states' institutional arrangements, requirement, and capacity.
(iii) (i) Provide input to the terms of reference for the financial management component of the CRM and (ii) participate in annual CRMs.
(iv) Update and monitor key financial management indicators annually for all states/UTs, which shall also be verified on a sample basis during the CRM.
(v) Continue to undertake training and capacity building for all states/UTs in the use of accounting and other financial management software.
(vi) Review and follow-up on resolution of audit recommendations.
(vii) Monitor unspent advances.
(viii) Recruit additional accountants at ULB levels based on the recruitment plan.

[12] Program Fiduciary Systems Assessment (accessible from the list of linked documents in Appendix 2).
[13] The statements of audit needs discussed with FMG, MOHFW during the fact finding mission in September 2014 is in Annex 3.

2. Procurement System

a. Summary of the Procurement System

38. The program will entail procurement of civil works, drugs and clinic consumables; clinic furniture and equipment; and consulting services, all sourced domestically. Overall procurement risk is substantial mainly due to (i) lack of adequately trained staff, especially in some states and sub-states entities; and (ii) inadequate quality assurance mechanism and supply management, especially for drugs, in some states. Strong mitigation measures are incorporated in DLI 6 (capacity development) and PAP (e.g., pre- and post-delivery quality check of drugs and annual post-procurement review of 5 states). The program will strengthen the implementation of NHM Governance and Accountability Framework, grievance redress mechanism (GRM), and community processes in monitoring of service delivery.

b. Procurement System Related Program Actions

39. The following are the key procurement system-related program actions (as included in the PAP in section VI):

(i) Prepare annual procurement plans along with program implementation plans (PIPs) in prescribed format.
(ii) Establish procurement oversight and contract management framework in the SPMUs. Under overall supervision of national PMU, engage specialized agencies/individuals to provide procurement training to staff responsible for procurement, especially civil works.
(iii) Conduct independent pre- and post-delivery drug quality audits, covering a sample of five states each year.
(iv) Conduct independent procurement and contract management audits, covering a sample of five states each year.
(v) (i) Monitor implementation of NHM Governance and Accountability Framework in NUHM; (ii) assess the effectiveness of community and facility-based GRMs; and (iii) strengthen community and facility-based GRMs.

3. Anticorruption System

a. Summary of Anticorruption System and Related Program Actions

40. The NHM Framework for Implementation provides a clear Governance and Accountability Framework, which include program governance and oversight mechanisms at national and state levels, systems for monitoring and audit, and accountability mechanisms involving community monitoring structures at level of service delivery.[14] The program will reinforce implementation of the NHM Governance and Accountability Framework and also assess the effectiveness of community- and facility-based grievance redressal mechanisms in urban areas and strengthen them during the program period (as included in PAP in section VI). ADB's anticorruption policy has been communicated with MOHFW. This includes blacklisting of

[14] Government of India, Ministry of Health and Family Welfare. 2012. *Framework for Implementation of the National Health Mission, 2012−2017*. Delhi.

corrupt contractors and service providers and the monitoring role of ADB's Office of Anticorruption and Integrity.[15]

C. Safeguard Systems

1. Summary of Safeguard System

41. The safeguard categorization for environment is B, for involuntary resettlement is C, and for Indigenous Peoples is C. Potential environmental impacts include those from construction/refurbishing of urban primary health facilities and generation of biomedical waste and infection risks during operation. The program safeguard system assessment examined environmental safeguard management and compliance aspects of NHM relative to ADB's Safeguard Policy Statement. The assessment found that a wide range of policies, laws, and regulations related to environmental issues are in place. The existing guidelines related to environmental management will be strengthened to guide central and state institutions and health facilities in urban areas. Environment and social safeguard elements will be incorporated in the quality assurance tools to ensure proper monitoring and compliance. For potential impact of involuntary resettlement from the program's civil work, a screening procedure has been developed to ensure that the program excludes any activities that may trigger category A or B. PAP includes raising awareness, human resource, and enforcement of specific environmental regulations. A program level initial environment examination (IEE) including a standard environmental management plan (EMP) has been prepared to assess the potential environmental impact, and to guide stakeholders to adopt appropriate mitigation or management measures to address any particular impact arising at subproject level.[16] IEE and EMP, along with technical assistance from ADB, will inform the IMEP/quality assurance updating and strengthening.

2. Safeguard System Related Program Actions

42. The following are the key safeguard system-related program actions (as included in the PAP in section VI):

(i) Engage a qualified and experienced social and environmental safeguard monitoring consultant to: (i) screen state PIPs to identify sites which may have social and environmental impacts; and (ii) monitor implementation of IMEP on sample basis. The consultant will provide an independent report on each site to MOHFW and ADB on the findings and recommendations.
(ii) Provide awareness and capacity building training to staff of the Infrastructure Wing of the State Health Departments through a well-developed modules on social and environmental safeguard aspects.
(iii) Review and update IMEP/quality assurance guidelines, including issuing detailed tools to strengthen and monitor compliance of environmental regulations.
(iv) Assess and build capacity of states/ULBs/facilities to ensure compliance with IMEP/quality assurance guidelines.
(v) Strengthen existing GRMs at the state and community levels.

[15] ADB. 2013. Guidelines to Prevent or Mitigate Fraud, Corruption, and Other Prohibited Activities in Results-Based Lending for Programs. Appendix 7 in ADB. *Piloting Results-Based Lending for Programs*. Manila.

[16] As all UPHCs and UCHCs will be less than 20,000 square feet, the national environmental framework does not require an environmental impact assessment, disclosure of initial environmental examination, or an environmental management plan for each subproject. MOHFW, therefore, prepared a program level IEE and a standard EMP to fill the gaps and ensure that the program is in line with ADB's SPS (2009).

D. Gender and Social Dimensions

43. The program recognizes that women and the poor suffer disproportionately from poor health outcomes. It therefore has a strong gender and pro-poor focus. Health interventions supported under the program directly target the poor while also allocating greater resources to the needs of women and girls, especially their reproductive health. Health service providers will be trained to be responsive to specific needs and concerns of women and girls and to improve their interactions with poor and marginalized communities. Through community outreach and counselling services, women and girls will be empowered to realize their health rights, including those related to gender-based violence. The program will also help improve women health workers' working conditions and career trajectories.

44. The following gender and social equity action plans are identified and included in the PAP in section VI:

(i) Engage a qualified and experienced consultant to (i) provide gender and social equity-related inputs to appraisal of PIPs, guidelines, and frameworks on community processes, capacity building, and innovations and partnerships; (ii) monitor and report on community processes and gender and social equity actions under NUHM; and (iii) mainstream gender considerations in various trainings under NUHM.

(ii) Sensitize and train frontline and clinical health workers, as part of their regular training programs, to be responsive to specific needs and concerns of women and girls and to improve their interactions with poor and marginalized communities.

(iii) Incorporate gender-based violence prevention and addressing its consequences within scope of sexual and reproductive health services, including community outreach and awareness-raising and referrals to social services.

(iv) Promote skill up-gradation and training opportunities for career progression of community workers/link workers and monitor progress.

(v) Promote equal opportunity measures in recruitment of new staff across state PMUs, city PMUs, and district PMUs. Collect a baseline of existing staff to set an appropriate gender target for new staff recruitment. Maintain sex-disaggregated data on new and existing staff dedicated to NUHM.

E. Communication and Information Disclosure Arrangements

45. NUHM related information will be communicated and disclosed through MOHFW and related agencies' websites at national and state level. Information disclosure requirements will follow the relevant rules and regulations. Community processes and outreach services will ensure participation of beneficiaries, i.e., urban population, especially the poor and vulnerable, in local decision making process. This will be monitored through community and facility based grievance redress mechanisms.

V. INTEGRATED RISKS AND MITIGATING MEASURES

A. Key Risks and Mitigating Measures

Table 4: Integrated Risk Assessments and Mitigating Measures
(As of March 2015)

Risks	Rating Without the Mitigating Measures	Key Mitigating Measures
Results		
Gaps among states in health status, institutional arrangements for urban health, and implementation capacity which may delay NUHM implementation and achievement of results.	Substantial	A capacity development framework is included to enhance implementation capacity, especially in lagging states. Attached capacity development TA will assess and monitor state-level institutional capacity to assist MOHFW in developing and implementing the framework
Challenges of coordinating collection of results indicators across multiple information systems, divisions, and agencies, as well as implementing capacity building activities to improve quality and completeness of data, may undermine proper measurement of results.	Moderate	NUHM results framework, DLIs, and PAP already identifying appropriate data for results to be captured and their sources. Attached capacity development TA to strengthen the capacity of MIS officers and DEOs and undertake independent assessment of results which will help enhance MOHFW's existing M&E systems. MOHFW to provide technical and implementation support at state and sub-state level to align the M&E systems and improve quality and timely availability of necessary data.
Expenditure and Financing		
Relatively low fund utilization capacity during first years after NUHM approval.	Moderate	MOHFW to ensure realistic planning and budgeting in the state PIPs, help increase implementation capacity of the states/UTs, by introducing clear business processes, allocating adequate resources for human resources, and providing technical support for implementation.
Fiduciary		
a. Financial Management		
The optimal funds flow arrangement, at city and district levels yet to be decided in some states.	Moderate	FMG to prepare and pilot models for city and district level funds flow set-up.

Risks	Rating Without the Mitigating Measures	Key Mitigating Measures
Inadequate number of staff trained for accounting and internal control and financial reporting, especially at some state and sub-state entities, that causes (i) delay in financial reporting and auditing and (ii) reports with inaccurate data in some ULBs	Substantial	MOHFW to support states to increase qualified human resources by allocating adequate resources for staff and technical support, and states to fill vacant financial management positions with qualified persons and provide training. FMG to ensure the agreed statement of audit needs are followed.
FMG's progress monitoring role needs to be further strengthened to develop and improve financial management at state and sub-state levels.	Substantial	FMG to update fiduciary performance indicators, strengthen its performance monitoring process, and support state / ULB staff capacity enhancement, especially for states with weak capacity. FMG to more rigorously monitor resolution of external audit observations. FMG to review and update the existing financial management monitoring framework (TORs for CRM), incorporating ADB inputs. ADB to participate in the annual CRMs to monitor the progress in financial management actions.
Delays in fund flow due to change in government policy requiring funds to be channeled through state treasuries rather than directly through state health societies	Substantial	MOHFW and states to increase monitoring and follow-up of timely fund releases with state authorities and finance department.
b. Procurement		
Delays in preparation of annual procurement plans in some states.	Moderate	All states to submit the annual procurement plans in a timely manner as part of the PIPs.
Procurement delays due to shortage of trained professionals in SPMUs/PWD/ULBs and lack of SBDs in most states.	Moderate	MOHFW to support states to increase qualified human resources by allocating adequate resources for staff and technical support, and SPMUs to set up dedicated procurement units with adequate number of trained procurement professionals and provide regular training at accredited institutions. SBDs to be developed and implemented.
Delays in contracting and implementation of civil works and inadequate capacity to monitor quality in some states.	Moderate	State Procurement Department or engineering division of state health departments or districts to (i) organize civil works into larger packages to attract qualified contractors; (ii) ensure wide publicity of procurement notices (ii) strictly adhere to quality control requirements; and (iii) establish

Risks	Rating Without the Mitigating Measures	Key Mitigating Measures
		progress reporting system.
Mechanism for ensuring quality of drugs needs strengthening in some states	Substantial	State Procurement Departments to apply more stringent quality requirement in manufacturing facilities and introduce or strengthen quality check at pre- and post-dispatch by commissioning independent test agencies or firms.
Gaps in supply chain management affecting availability of drugs in some states.	Substantial	State to adopt a computerized stores management system to monitor fast moving drugs, develop procurement plan considering lead time for contracting, order and delivery, and use rate contracts.
Insufficient procurement supervision and monitoring by some SPMUs.	Moderate	(i) SPMUs to establish a computerized program monitoring system, undertake quarterly review meetings, and prepare quarterly reports. (ii) NPMU to undertake post procurement reviews for five states every year through an independent agency to provide feedback to SPMUs
c. Anti-corruption		
Community processes and other feedback mechanisms of NUHM still at early stage to ensure better accountability of health service providers	Moderate	(i) MOHFW to support state and cities in strengthening the existing and planned community and facility based grievance redress mechanisms to increase accountability of stakeholders (ii) MOHFW to support state and cities in implementing the NHM Governance and Accountability Framework
Safeguards		
Low level of understanding among health staff of guidelines, environmental standards, and good practices	Moderate	MOHFW and states to conduct long-term awareness creation programs and social and environmental safeguard orientation and training programs for all levels of health staff
Existing grievance redress mechanisms may not adequately address social safeguard issues	Moderate	MOHFW to strengthen the existing and planned community and facility based grievance redress mechanisms to include potential social safeguard issues
Overall RBL Program Risk	**Substantial**	

ADB = Asian Development Bank, CRM = Common Review Mission, DEO = data entry operator, DLI = disbursement-linked indicator, FMG = Financial Management Group, M&E = Monitoring and Evaluation, MIS = management information system, MOHFW = Ministry of Health and Family Welfare, NHM = National Health Mission, NPMU = National Program Management Unit, PAP = program action plan, PIP = program implementation plan, PMU = program monitoring unit, PWD = Public Works Department, SBD = standard bidding document, SHS = state health society, SOAN = statement of audit needs, SPMU = State Program Management Unit, TA = technical assistance, TOR = terms of reference, ULB = urban local body, UT = union territory.
Source: Asian Development Bank

VI. PROGRAM ACTION PLAN

A. Program Action Plan

Table 5: Program Action Plan
(As of February 2015)

Actions	Responsible Agency	Time Frame for Implementation
Area 1: Program Technical Aspects		
1.1. (i) Analyze NFHS results (2014–2015) related to urban health and strengthen implementation strategies for NUHM; (ii) monitor health outcomes related to diarrhea and ARI using NFHS (2014–2015) data onwards; and (iii) analyze NFHS (2014–2015) data to assess equity and compare trends in achievement for DLI 1 and 2 during the midterm review.	MOHFW	2016 (after NFHS results become available)
1.2. Study and document structure and activities of MAS and other community institutions that have shown effective convergence and improved health-seeking behavior of the poor and vulnerable, from at least two settlements.	MOHFW	March 2016
1.3. (i) Conduct private health sector assessment in selected states, including existing experience of PPPs in primary health care and for improving referral linkages. (ii) Develop framework, guidelines, and templates for contracts for implementing health PPPs in the urban context.	MOHFW	March 2016
1.4. Participating states will (i) have State Health Societies that include members from Urban Development and Housing and Urban Poverty Alleviation Departments and (ii) issue joint circulars signed by Secretaries of Health and Family Welfare, Urban Development, and Housing and Urban Poverty Alleviation for joint planning, monitoring, and reporting in urban areas. MOHFW will facilitate such policy level inter-sectoral convergence through relevant NUHM guidelines and consultations with participating states.	MOHFW and participating states	March 2016
1.5. Where ULBs are not directly implementing the NUHM, MOHFW will facilitate, through the PIP guidelines and other relevant mechanisms, active participation of ULBs in state-level planning processes, including mapping of slums and vulnerable populations and location of health facilities.	MOHFW, participating states, and ULBs	From date of loan effectiveness onwards (align with ULB/state planning cycles)
1.6. Study and document experiences of adoption of Clinical Establishments Act, 2010 and other regulatory efforts for improving quality of private sector health services.	MOHFW	March 2018
1.7. Ensure quality assurance mechanism (supported under DLI 5) addresses quality of institutional deliveries and antenatal care, including through (i) assessment of antenatal care quality at PHC level (e.g., in screening for complications); (ii) use of safe birth checklists and perinatal and maternal death audits at facilities to be	MOHFW	March 2017

Actions	Responsible Agency	Time Frame for Implementation
referred by UPHCs for childbirth delivery; and (iii) review adequacy of JSY accreditation requirements for ensuring quality care.		
Area 2: Financial Management		
2.1. Submit annual audited financial statement in accordance with detailed statement of audit needs.	MOHFW, FMG	By 31 Dec annually
2.2. Develop detailed fund flow mechanism for cities and districts after consideration of individual states' institutional arrangements, requirements, and capacity.	MOHFW, FMG	By loan inception mission
2.3. (i) Provide input to the TORs for the financial management component of the CRM and (ii) participate in annual CRMs.	ADB	(i) By loan inception mission (ii) annually
2.4. Update and monitor key financial management indicators annually for all states/UTs, which shall also be verified on a sample basis during the annual CRMs.	MOHFW, FMG	Annually
2.5. Continue to undertake training and capacity building for all states/UTs in the use of the PFM System as well as Integrated Tally software.	MOHFW, FMG	Annually
2.6. Review and follow-up on resolution of statutory and concurrent auditor recommendations.	MOHFW, FMG	Annually
2.7. Monitor unspent advances.	MOHFW, FMG	Annually
2.8. Recruit additional accountants in states, including at ULB levels, based on the recruitment plan.	MOHFW, states, ULBs	By 2015
Area 3: Procurement		
3.1. Prepare annual procurement plans along with PIPs in prescribed format.	State PMUs	By December each year
3.2. Establish procurement oversight and contract management framework in the state PMUs. Under overall supervision of national PMU, engage specialized agencies/individuals to provide procurement training to staff responsible for procurement, especially civil works.	State PMUs	From January 2016, onwards
3.3. Conduct independent pre- and post-delivery drug quality audits, covering a sample of five states each year.	National PMU with third-party/ independent agencies	From January 2016, onwards
3.4. Conduct independent procurement and contract management audits, covering a sample of five states each year.	National PMU with third-party/ independent agencies	From January 2016, onwards
3.5. (i) Monitor implementation of NHM Governance and Accountability Framework in NUHM; (ii) assess the effectiveness of community and facility-based GRMs; and (iii) strengthen community and facility-based GRMs.	MOHFW and states	From January 2016, onwards

Actions	Responsible Agency	Time Frame for Implementation
Area 4: Safeguards		
4.1 Engage a qualified and experienced social and environmental safeguard monitoring consultant to: (i) screen state PIPs to identify sites which may have social and environmental impacts; and (ii) monitor implementation of IMEP on sample basis. The consultant will provide an independent report on each site to MOHFW and ADB on the findings and recommendations.	MOHFW	From loan effectiveness, onwards
4.2 Provide awareness and capacity building training to staff of the Infrastructure Wing of the State Health Departments through a well-developed modules on social and environmental safeguard aspects.	MOHFW, with state PMUs	From loan effectiveness, onwards
4.3 Review and update IMEP/quality assurance guidelines, including issuing detailed tools to strengthen and monitor compliance of environmental regulations.	MOHFW	March 2016
4.4 Assess and build capacity of states/ULBs/facilities to ensure compliance with IMEP/quality assurance guidelines.	MOHFW	March 2016
4.5 Strengthen existing GRMs at the state and community levels.	MOHFW, states	June 2016
Area 5: Monitoring and Evaluation		
5.1 Review and strengthen HMIS and MIS indicators to adequately capture key processes and outcomes related to urban health and NUHM implementation framework (e.g., referrals, diarrhea).	MOHFW	By March 2016
5.2 Include quality assurance module in HMIS formats to reflect quality aspects of health services delivery, as per Quality Assurance Guidelines, 2013.	MOHFW	From December 2015
5.3 CRM reports of NHM will substantively review NUHM and urban health issues with recommendations and action plans to traverse gaps, if any.	MOHFW	Annually, from loan effectiveness onwards
5.4 (i) Develop NUHM MIS, by adapting existing NRHM MIS formats, to meet NUHM program reporting requirements, including on key indicators, components, and processes; (ii) generate NUHM program quarterly and annual progress reports.	MOHFW	(i) By loan inception mission (ii) from April 2015
Area 6: Gender and Social Equity		
6.1 Engage a qualified and experienced consultant to (i) provide gender and social equity-related inputs to appraisal of PIPs, guidelines, and frameworks on community processes, capacity building, and innovations and partnerships; (ii) monitor and report on community processes and gender and social equity actions under NUHM; and (iii) mainstream gender considerations in various trainings under NUHM.	MOHFW	By August 2015

Actions	Responsible Agency	Time Frame for Implementation
6.2 Sensitize and train frontline and clinical health workers, as part of their regular training programs, to be responsive to specific needs and concerns of women and girls and to improve their interactions with poor and marginalized communities.	MOHFW and states	From March 2016
6.3 Incorporate gender-based violence prevention and addressing its consequences within scope of sexual and reproductive health services, including community outreach and awareness-raising and referrals to social services.	MOHFW and states	From March 2016
6.4 Promote skill up-gradation and training opportunities for career progression of community workers/link workers and monitor progress.	MOHFW and states	From March 2016
6.5 Promote equal opportunity measures in recruitment of new staff across state PMUs, city PMUs, and district PMUs. Collect a baseline of existing staff to set an appropriate gender target for new staff recruitment. Maintain sex-disaggregated data on new and existing staff dedicated to NUHM.	MOHFW and states	From March 2016

ADB = Asian Development Bank, ARI = acute respiratory infections, CRM = Common Review Mission, DLI = disbursement-linked indicator, FMG = Financial Management Group, GRM = grievance redressal mechanism, HMIS = Health Management Information System, IMEP = Infection Management and Environment Plan, JSY = Janani Suraksha Yojana, MAS = Mahila Arogya Samitis, MIS = management information system, MOHFW = Ministry of Health and Family Welfare, NFHS = National Family Health Survey, NHM = National Health Mission, NUHM = National Urban Health Mission, NRHM = National Rural Health Mission, PFM = public financial management, PHC = primary health center, PIP = program implementation plan, PPP = public–private partnership, PMU = program management unit, TOR = terms of reference, ULB = urban local body, UPHC = urban primary health center, UT = union territory.
Source: Asian Development Bank.

VII. TECHNICAL ASSISTANCE

A. Summary

46. An accompanying capacity development TA of $2 million will be financed on a grant basis by the Japan Fund for Poverty Reduction and administered by ADB. The TA has the following broad components: (i) state-level institutional capacity gap analyses; (ii) monitoring, verification, and reporting of program results; and (iii) developing and learning from innovations for urban health. The TA activities will focus on states with strong ADB urban sector presence to enhance synergy between urban and health sector interventions.

B. Implementation Arrangements

47. MOHFW will be the executing agency. The National Health Mission Steering Group under the Union Health Minister, the Empowered Program Committee under the Secretary of MOHFW, and the National Program Coordination Committee under the Mission Director/NHM will guide and oversee NUHM implementation including the program. The Urban Health Division of MOHFW will be the implementing agency, coordinating program activities and supporting the State Health Societies for activities at state level. The State Health Departments, and in some cases the ULBs, will prepare periodic monitoring reports on progress towards DLIs and PAP within the overall NUHM framework. MOHFW will consolidate state level reports and submit periodic monitoring reports on progress towards DLIs and PAP and other key performance indicators set for NUHM and prepare DLI achievements report for disbursement purposes.

C. Consulting Service Requirement

48. ADB will engage a firm to provide a total of 113 person-months of consulting inputs (51 person-months of international and 62 person-months of national consultants). The selection and engagement of the consulting inputs will be carried out in accordance with ADB's Guidelines on the Use of Consultants (2013, as amended from time to time). The consulting firm will be selected on the basis of full technical proposal in accordance with the quality- and cost-based selection procedures. Given the highly specialized nature of some of the tasks proposed under the capacity development TA, a quality to cost ratio of 90:10 will be followed. All disbursements under the TA will be done in accordance with ADB's Technical Assistance Disbursement Handbook (2010, as amended from time to time). All TA-financed goods and equipment such as office equipment will be procured in accordance with ADB's Procurement Guidelines (2013, as amended from time to time). The equipment will be handed over to MOHFW upon TA completion. The TA will be implemented over 36 months from the fielding of the consultants, which is anticipated in July 2015. Thus, the TA is expected to be completed in June 2018.

VIII. ACCOUNTABILITY MECHANISM

49. The Accountability Mechanism provides an independent forum and process whereby people adversely affected by ADB-assisted operations can voice, and seek a resolution of their problems, as well as report alleged violations of ADB's operational policies and procedures.[17] People who are, or may in the future be, adversely affected by a program supported by RBL may submit complaints to ADB's Accountability Mechanism (2012).

[17] ADB. 2012. *Review of the Accountability Mechanism Policy*. Manila.

50. Before submitting a complaint to the Accountability Mechanism, affected people should make a good faith effort to resolve their problems and/or issues by working with the concerned ADB operations department. Only after doing that, and if they are still dissatisfied, they approach the Accountability Mechanism.

IX. PROGRAM ORGANIZATIONAL STRUCTURE AND FOCAL STAFF

A. Organizational Structure

51. The broad NUHM organizational structure is presented in the NUHM Implementation Framework (chapter 7).

B. Program Officers and Focal Persons

1. Initial Arrangements

Table 6: Program Officers and Focal Persons
(As of February 2015)

Number	Key Government Staff and Positions	Key ADB Staff and Positions
1	Mr. Nikunja B. Dhal Joint Secretary Ministry of Health and Family Welfare 150-A, Nirman Bhavan, New Delhi, 110001 nbdhal@gmail.com	Sungsup Ra, Director Human and Social Development Division South Asia Department Hayman Win Social Sector Specialist Gi Soon song Principal Social Sector Specialist Brian Chin Social Sector Economist
2	Ms. Preeti Pant Director Ministry of Health and Family Welfare 311-D, Nirman Bhawan, New Delhi, 110001 p.preeti@nic.in	

ANNEX 1

PROGRAM RESULTS FRAMEWORK

(As of February 2015)

Results Indicators[1]	DLI (Yes/No)	Baseline Value	Baseline Year	Target Values of Results Indicators				
				2015	2016	2017	2018	2019
Outcome: More equitable and quality urban health system								
Increased institutional delivery in urban areas (Percentage by urban wealth quintile)	**Yes**	Available by urban area and wealth quintile in 2015 from HMIS, and in 2016 from NFHS-4	2014[2]	HMIS (85%)	HMIS (87%) NFHS-4 (80%)	HMIS (89%)	HMIS (91%)	HMIS (93%), NFHS-5 (90%)
Increased complete immunization among children less than 12 months age (Percentage by urban wealth quintile and by sex)	**Yes**		2014[3]	HMIS (88%)	HMIS (90%) NFHS-4 (80%)	HMIS (92%)	HMIS (94%)	HMIS (96%), NFHS-5 (90%)
Reduced prevalence of communicable disease as evidenced by (i) Percentage of children who had diarrhea in the last 2 weeks; (ii) medically treated TB	**No**	Available in 2016 from NFHS4 (by wealth quintile and by sex for [i] and [ii])	2014[4]		NFHS-4 (i) 6% (ii) 300			NFHS-5 (i) 2% (ii) 200
Reduced household out-of-pocket expenditure on total health care expenditure (by urban wealth quintile)	**No**	Available in 2016 from NSSO/NHA	2014		NSSO/ NHA (60%)			NSSO/ NHA (40%)
Increased antenatal care coverage of 3 or more visits in urban areas	**No**	Available in 2016 from NFHS-4 (by wealth quintile)	2014[5]		NFHS-4 (90%)			NFHS-5 (100%)
1. City specific primary health care delivery system established								
1.1. Percentage of cities targeted for support under NUHM have their PIPs approved by 31 March 2015	**Yes**		2014	90%				
1.2. Percentage of cities whose PIPs were approved by 31 March 2015 have (i) completed mapping of slums and vulnerable population and health facilities (ii) developed 'city health plans' reflecting inter-sectoral convergence	**(i) Yes (ii) No**		2014	(i) 25% (initiated) (ii) 25%	80% (completed) (ii) 80%			
1.3. Percentage of UPHCs approved as	**Yes**		2014		40%	70%	90%	95%

[1] Targets are national urban aggregate. Specific goals/ targets for the states will be based on existing levels, capacity and context.
[2] Urban overall is 67.4%, for non-poor is 78.5%, and for poor is 44%, in NFHS-3 (2005-06)
[3] For children receiving measles immunization, urban overall is 71.8%, non-poor is 80.1%, and for poor is 52.6% in NFHS-3 (2005-06)
[4] (i) 8.9% for both urban poor and non-poor, (ii) for urban overall 307 per 100,000, for non-poor 258 per 100,000, for poor is 461 per 100,000 in NFHS-3 (2005-6)
[5] Urban overall is 74.7%, for non-poor is 83.1%, for poor is 54.3% in NFHS-3 (2005-6)

Results Indicators[1]	DLI (Yes/No)	Baseline Value	Baseline Year	Target Values of Results Indicators				
				2015	2016	2017	2018	2019
of 31 March 2015 meet the minimum requirements for staffing and service package								
1.4. Percentage of UPHCs with formal referral system in place for improved continuum of care	**No**	1 UCHC may be set up as referral unit every 4-5 UPHCs; existing hospitals may be empanelled to act as referral points (referral facilities to be identified through GIS mapping)	2014		70%	80%	90%	100%
1.5. Number of UPHCs established, meeting NUHM norms for population coverage	**No**	Existing urban health facilities to be revamped and new urban health facilities need to be established, to meet city-specific needs for primary health care services	2014 (1,402 new UPHCs sanctioned as of FY2014−2015)	1,000	1,400	1,800	3,000	4,500
2. Community outreach services improved								
2.1. *Guidelines for ASHA and MAS in the Urban Context* are issued and disseminated at the state level (Y/N)	**Yes**		2014	Yes				
2.2 Training modules based on the *Guidelines for ASHA and MAS in the Urban Context* are issued in Hindi and some regional languages (Y/N)	**Yes**		2014	Yes				
2.3. (i) number of recruited ASHAs are trained and (ii) Percentage of recruited ASHAs are functional	**Yes**	No ASHAs with specific skills and roles to work in urban context in service in 2014	2014		(i)15,000 (ii) 80%	(i) 23,000 (ii) 85%	(i) 31,000 (ii) 90%	(i) 35,000 (ii) 90%
2.4. (i) Percentage of slums/ settlements covered by ASHA and (ii) Percentage of slums/ settlements covered by MAS (or equivalent structure in urban areas)[6]	**No**		2014		40%	60%	70%	
2.5. Effective outreach as evidenced by (i) Percentage of urban poor children who had diarrhea in the last 2 weeks who received ORS (ii) Percentage urban poor households using a sanitary facility	**No**	(i) 24.9%; (ii) 47.2% in NFHS-3 (2005-6)			NFHS (i) 70% (ii) 80%			NFHS (i) 100% (ii) 100%

[6] Settlement defined (200-500 hh [1000-2500ppl]) as referenced in NHM Institutions of Governance. *NHM Operations for preparing and monitoring of state PIPs, p. 3.*

Results Indicators[1]	DLI (Yes/No)	Baseline Value	Baseline Year	Target Values of Results Indicators				
				2015	2016	2017	2018	2019
for the disposal of excreta (flush/ pit toilet)								
3. Quality of urban health services improved								
3.1. Effective system of quality assurance for urban health services implemented	**Yes**	QA mechanism for UPHCs to be developed and implemented	2015	See DLI 5 in DLI Matrix	See DLI 5 in DLI Matrix	See DLI 5 in DLI Matrix	See DLI 5 in DLI Matrix	See DLI 5 in DLI Matrix
3.2. Increased number of facilities registered under the Clinical Establishments Act, MOHFW, 2010	**No**	[baseline to be established and targets to be set]						
3.3. Percentage maternal health delivery points introducing standard treatment protocols for child birth delivery	**No**	[baseline to be established and targets to be set]						
4. Planning, management and monitoring capacity to deliver urban health services strengthened								
4.1. Capacity development needs in planning, management and monitoring are identified and addressed	**Yes**	NUHM requires a comprehensive capacity development to deliver the mission	2015	See DLI 6 in DLI Matrix	See DLI 6 in DLI Matrix	See DLI 6 in DLI Matrix	See DLI 6 in DLI Matrix	See DLI 6 in DLI Matrix
4.2. Strengthened public health capacity of ULBs, as evidenced by, number of municipal health officers carrying out defined public health functions	**No**	[baseline to be established and targets to be set]						
5. Capacity for innovation and knowledge sharing strengthened								
5.1. Innovations and partnerships in urban health developed, tested and shared	**Yes**	Innovations in urban health are not well evaluated, documented, and disseminated; incentive mechanisms for encouraging innovations is weak		See DLI 7 in DLI Matrix	See DLI 7 in DLI Matrix	See DLI 7 in DLI Matrix	See DLI 7 in DLI Matrix	See DLI 7 in DLI Matrix

ASHA = Accredited Social Health Activist, DLI = disbursement-linked indicator, GIS = geographic information system, HMIS = health management information system, MAS = Mahila Arogya Samiti, MOHFW = Ministry of Health and Family Welfare, NFHS = National Family Health Survey, NHA = National Health Accounts, NUHM = National Urban Health Mission, NSSO = National Sample Survey Office, ORS = oral rehydration salt, QA = quality assurance, UCHC = urban community health center, ULB = urban local body, UPHC = urban primary health center.
Source: Asian Development Bank.

ANNEX 2

DISBURSEMENT-LINKED INDICATORS, VERIFICATION PROTOCOLS, AND DISBURSEMENT SCHEDULE

Table A1: Disbursement-Linked Indicators[1]

(As of March 2015)

Disbursement Linked Indicators	Baseline Year and Value	Target Values					
		Prior results	2015	2016	2017	2018	2019
Outcome: Increased access to equitable and quality urban health system							
DLI 1 Increased institutional deliveries in urban areas	Nationally 85.3% in FY2013[2]	—	—	2% point increase with respect to FY2014[3]	2% point increase with respect to FY2015	2% point increase with respect to FY2016	2% point increase with respect to FY2017
DLI 2 Increased complete immunization among children below 12 months of age in urban areas	Nationally 88.4% in FY2013[3]	—	—	2% point increase with respect to FY2014[4]	2% point increase with respect to FY2015	2% point increase with respect to FY2016	2% point increase with respect to FY2017
Output 1: Urban primary health care delivery system strengthened							
DLI 3 City-specific primary health care delivery system established	As of 2014, urban health facilities are limited in number, service package, and quality to	(i) At least 90% of cities included for support under NUHM have their respective State PIPs	At least 25% of cities with approved PIPs have initiated mapping of slums and vulnerable	(i) At least 55% of cities with approved PIPs have completed mapping of slums and	50% of UPHCs meet the minimum requirements for staffing and service package	60% of UPHCs meet the minimum requirements for staffing and service package	70% of UPHCs meet the minimum requirements for staffing and service package

[1] The grey shaded areas are indicative results for additional financing from 2018 to 2019. The indicative targets will be critically reviewed based on the performance during the current program period and revised as required.

[2] These baselines are national average (including both rural and urban) from the current HMIS. HMIS is being strengthened to report urban-rural disaggregated data, and urban-specific baseline will be established by May 2015 based on the data collected by March 2015.

[3] Target value (2% points from the previous year level) is based on assessment of historical trends and consideration of accelerated progress under NUHM.

Disbursement Linked Indicators	Baseline Year and Value	Target Values					
		Prior results	2015	2016	2017	2018	2019
	address urban health issues	approved by FY2014 (ii) Norms for identification of vulnerable populations established.	population and health facilities	vulnerable population and health facilities (ii) 30% of UPHCs meet NUHM minimum requirements for staffing and service package			
DLI 4 Community processes improved	ASHAs are active in rural areas, and those with adequate skills and roles in urban context is not yet available in 2014	*Guidelines for ASHA and MAS in the Urban Context* are issued and disseminated at state level	Training modules based on the *Guidelines for ASHA and MAS in the Urban Context* are issued in Hindi and some regional languages	(i) 15,000 of recruited ASHAs are trained (ii) 80% of recruited ASHAs are functional	(i) 23,000 of recruited ASHAs are trained (ii) 85% of recruited ASHAs are functional	(i) 31,000 of recruited ASHAs are trained (ii) 90% of recruited ASHAs are functional	(i) 35,000 of recruited ASHAs are trained (ii) At least 90% of recruited ASHAs are functional
Output 2 : Quality of urban health services improved							
DLI 5 Effective system of quality assurance for urban health services implemented	QA mechanism for NRHM exists in 2014 but it needs to be adapted and adopted by NUHM to guide sub-national entities to address urban specific issues	*MOHFW Operational Guidelines for Quality Assurance (QA) in Public Health Facilities* issued and disseminated	QA Assessor Guidebook and tools are developed for UPHCs, reflecting *MOHFW Operational Guidelines for Quality Assurance*	(i) 15 states/ UTs/ Large ULBs have set up organizational arrangements for QA of health facilities, that include UPHCs and UCHCs	(i) 20 cumulative states/ UTs/ Large ULBs have set up organizational arrangements for QA of health facilities, that include UPHCs and	(i) 40% of UPHCs and UCHCs in the 20 states/ UTs/ ULBs received national or state-level quality certification;	Based on the review MOHFW prepared and approved a time-bound action plan to further improve: (a) quality of urban primary

Disbursement Linked Indicators	Baseline Year and Value	Target Values					
		Prior results	2015	2016	2017	2018	2019
			(QA) in Public Health Facilities	(ii) 50% of UPHCs and UCHCs in those states/UTs/ ULBs are assessing the quality of their services, including patient satisfaction	UCHCs (ii) 80% of UPHCs and UCHCs in those states/UTs/ ULBs are assessing the quality of their services, including patient satisfaction	(ii) MOHFW conducted a comprehensive independent review of the QA program with states focusing on (a) the quality of urban primary health care services, and (b) effectiveness of quality assurance mechanism	healthcare services; and (b) quality assurance mechanism
Output 3: Capacity for planning, management, and innovation and knowledge sharing strengthened							
DLI 6 Planning, management and monitoring capacity to deliver urban health services strengthened	NUHM is a new program, and requires a comprehensive capacity development to deliver the mission.	(i) At least 30% staff sanctioned for NUHM at SPMUs, DPMUs and CPMUs are in position.	(i) NUHM capacity development framework is developed, specifying priority areas for capacity development and implementation support; outputs and targets; modalities; and progress	(i) At least 30% staff sanctioned for NUHM at SPMUs, DPMUs and CPMUs are in position.	NUHM capacity development framework implementation achieved at least 60% of annual targets at national level and in 20 states/UTs in priority areas	Based on recommendations of the independent evaluation, MOHFW has updated the NUHM capacity development framework, including outputs and modalities	NUHM capacity development framework (updated) implementation achieved at least 75% of annual targets at national level and in 25 states/UTs in priority areas

Disbursement Linked Indicators	Baseline Year and Value	Target Values					
		Prior results	2015	2016	2017	2018	2019
			reporting mechanism (ii) HMIS is enhanced to include urban disaggregated data and has functionality to identify urban health facilities near poor and vulnerable populations (iii) The National PMU established a pool of experts for technical and implementation support at national and states/UTs/ ULB level	(ii) NUHM capacity development framework implementation achieved at least 50% of annual targets at national level and in 15 states/UTs in priority areas			
DLI 7 Innovations and partnerships in urban health developed, tested and shared	Innovative approaches exist, but not well evaluated, documented, and disseminated; incentive mechanism for encouraging	—	—	A framework for innovations and partnerships, including examples of good practices, is developed, approved, and implemented	50% of states/UTs/ large ULBs implement innovations and partnerships aiming at improving equity, access,	20 good practices in innovations and partnerships in at least 10 states/UTs/ large ULBs are demonstrated and	Incentive mechanisms for more innovation for equitable access to, and improved quality of, urban health services

Disbursement Linked Indicators	Baseline Year and Value	Target Values					
		Prior results	2015	2016	2017	2018	2019
	innovations is weak				or quality of urban health services	disseminated	including performance based financing

ASHA = accredited social health activist, CPMU = city program management unit, DPMU = district program management unit, FY = fiscal year, HMIS = health management information system, MAS = Mahila Arogya Samitis, MOHFW = Ministry of Health and Family Welfare, NRHM = National Rural Health Mission, NUHM = National Urban Health Mission, PIP = program implementation plan, PMU = project management unit, QA = quality assurance, ULB = urban local body, UCHC = urban community health center, UPHC = urban primary health center, UT = union territory.
Source: Asian Development Bank

Table A2: Verification Protocols

Disbursement-Linked Indicator	Definition and Description of Achievement and Verification Timeframe	Information Source and Frequency	Verification Agency and Procedure
Outcome: Increased access to equitable and quality urban health system			
DLI 1 Increased institutional delivery in urban areas	**Definition** Number of institutional deliveries in urban health facilities as a percentage of total number of reported deliveries, described as $\frac{\text{\# of institutional deliveries}}{\text{\# of institutional deliveries + \# of home deliveries}} \times 100$ Urban health facility includes public facilities and private facilities accredited under JSY (but not limited to these facilities)[4]. **March 2016** Institutional delivery has increased by 2% point or more from the FY2014 level, based on HMIS data. . **March 2017** Institutional delivery has increased by 2% point or more from the FY2015 level, based on the HMIS data.	HMIS, Annual	1. MOHFW Statistics Division will provide quarterly data on institutional delivery to the program division. The report will facilitate regular assessment of performance and gaps towards this target. 2. MOHFW Statistics Division will prepare HMIS data as of 31 March of each year or later date when the target is met.. An independent entity (firm) engaged by ADB under the piggy-backed TA will conduct spot reviews of HMIS in selected cities/states to ensure data quality and strengthen HMIS for initial two years. 3. MOHFW will provide ADB with a report certifying the annual percentage change in the institutional deliveries in urban health facilities based on the HMIS data. The report will include supporting tables of state-wise and all-India data including numerator and denominator.[5] 4. Within one month from receipt of MOHFW report, ADB will review the report and confirm if the DLI target is met.
DLI 2 Increased complete	**Definition** Complete immunization rate is measured by number of infants below 12 months (up to 1 year of age) who received measles vaccination[6] in urban	HMIS, Annual	1. MOHFW Statistics Division will provide quarterly data on institutional delivery to the program division. The report will facilitate

[4] Janani Suraksha Yojana is a central government scheme providing cash assistance for delivery and post-delivery care.
[5] While the focus of DLI 1 is on improving institutional delivery as measured by a percentage, attention will be paid on improving coverage and effectiveness of HMIS to capture increased total reported deliveries (both institutional as well as in the home), which forms the denominator of DLI 1.
[6] Measles vaccination, one of the last vaccinations provided for infants (up to 1 year of age), is used as a proxy for complete immunization.

Disbursement-Linked Indicator	Definition and Description of Achievement and Verification Timeframe	Information Source and Frequency	Verification Agency and Procedure
immunization among children below 12 months of age in urban areas	public facilities, including through outreach services, as a percentage of estimated annual number of infants, described as $\frac{\text{\# of measles vaccinations given}}{\text{annual estimated \# of infants}} \times 100.$ "Annual estimated number of infants" in urban areas from HMIS is based on SRS data. **March 2016** Complete immunization rate has increased by 2% point or more from the FY2014 level, based on HIMS. **March 2017** Complete immunization rate has increased by 2% point or more from the FY2015 level, based on HIMS.		regular assessment of performance and gaps towards this target. 2. MOHFW Statistics Division will prepare HMIS data as of 31 March or later date when the target is met. An independent entity (firm) engaged by ADB under the piggy-backed TA will conduct spot reviews of HMIS in selected cities/states to ensure data quality and strengthen HMIS for initial two years. 3. MOHFW will provide ADB with a report certifying the annual percentage change in the complete immunization in urban health facilities based on HMIS data. The report will include supporting tables of state-wise and all-India data including numerator and denominator. 4. Within one month from receipt of MOHFW report, ADB will review the report and confirm if the DLI target is met.
Output 1: Urban primary health care delivery system strengthened			
DLI 3 City-specific primary health care delivery system established	**Prior Result** (i) At least 90% of cities included for support under NUHM have their respective State PIPs approved by FY2014 (ii) Norms for identification of vulnerable populations established	FY2014 record of proceedings from MOHFW	1. (i) Upon loan effectiveness, MOHFW will certify that at least 90% of cities targeted for support under NUHM have their respective State PIPs approved by FY2014. The certification will attach an enumerated list of these cities. (ii) Upon loan effectiveness, MOHFW will provide ADB with a copy of approved checklist of vulnerable populations. 2. (i) ADB will verify if the number of cities with approved PIPs is at least 90% of cities targeted for support under NUHM.(ii) ADB

Disbursement-Linked Indicator	Definition and Description of Achievement and Verification Timeframe	Information Source and Frequency	Verification Agency and Procedure
			will verify if the checklist of vulnerable populations is published on NUHM or NHSRC website.
	March 2015 At least 25% of cities with approved PIPs have initiated mapping of slums, vulnerable populations, and health facilities. [Mapping includes (i) Listed and Unlisted Slums and vulnerable populations; and (ii) Existing Public and Private Health Facilities.] [Mapping is initiated when cities have mapped listed and unlisted slums and health facilities, using available sources of data, including GIS, from other departments.]	NUHM MIS (Progress Report), annual	1. By 1 July 2015, MOHFW will certify that at least 25% of cities with approved PIPs have initiated mapping of slums and vulnerable populations and health facilities. MOHFW certification will also include: a) list of cities whose PIP approved b) list of cities that have mapped listed and unlisted slums and health facilities, using available data, including GIS, from other departments. 2. By September 2015, ADB will review and verify MOHFW certification report and data.
	March 2016 (i) At least 55% of cities with PIP have completed mapping of slums, vulnerable populations and health facilities. [Mapping is completed when cities have mapped with listed and unlisted slums and health facilities and information on vulnerable populations, using available sources of data, including GIS, from other departments.]	NUHM MIS (Progress Report), annual	1. By 1 July 2016, MOHFW will certify that at least 55% of cities with approved PIPs have completed mapping of slums and vulnerable populations and health facilities. MOHFW certification will also include: (a) list of cities whose PIP approved (b) list of cities that have completed the mapping. 2. By September 2016, ADB will review and verify MOHFW report and data.
	(ii) 30% of UPHCs meet the minimum requirements for staffing and service package as a percentage of UPHCs approved for NUHM financing [**Minimum requirements** will be defined by MOHFW based on the existing norms of NUHM, and be agreed by ADB in 2015. To assess progress towards this	NUHM MIS (Progress Report), annual	For verification of this DLI from 2016 to 2019: 1. By 1 May every year from 2016 to 2019, State Missions will submit to MOHFW, facility-wise assessment of UPHCs against Minimum Requirements.

Disbursement-Linked Indicator	Definition and Description of Achievement and Verification Timeframe	Information Source and Frequency	Verification Agency and Procedure
	target, by end of 2015, MOHFW will develop and submit to ADB an assessment or evaluation process, including the assessment form that would be used by states, in determining compliance with staffing and services requirements. The minimum requirements may include the following elements: <u>Staffing</u> (i) At least one Medical Officer (full-time) who can be a civil servant or a contractual /contracted MD (ii) At least 2 Staff Nurses (full time civil servants) (iii) At least 2 ANMs (iv) A staff designated as the Pharmacist or dispenser of medicines (this staff can be a licensed pharmacist or a concurrent designation of the medical officer) (v) A staff designated as the Lab technician (a staff nurse can be trained and assigned the additional task of lab technician) (vi) A staff designated as Public Health Manager (the MD or a staff nurse can be given this function as a concurrent designation) (vii) One or two staff designated for account keeping and M&E (a staff can be designated to do both account keeping and M&E) (viii) <u>Service Package</u> (i) OPD Medical Care (at least 6 hours, these services include consultations and basic diagnostics) (ii) Services as prescribed under RMNCH+A (RMNCH+A is a new approach of the government to address the health problems of mother, newborn, child & adolescence simultaneously at different stages of life through		2. By 1 July every year from 2016 to 2019, MOHFW will provide ADB with a report certifying the percentage of UPHCs that meet the agreed Minimum Requirements. The report will include: ○ an enumerated list showing number of UPHCs that have been approved as of 31 March of the relevant fiscal year. ○ a certified list of UPHCs that meet Minimum Requirements, at the end of each fiscal year. 3. By September of each year, MOHFW and ADB will jointly conduct a validation of selected UPHCs out of the certified list.

Disbursement-Linked Indicator	Definition and Description of Achievement and Verification Timeframe	Information Source and Frequency	Verification Agency and Procedure
	'continuum of care') (iii) Collection and reporting of vital events and IDSP (iv) Referral Services (There should be referral paper forms or an electronic or mobile system as evidence of the presence of a referral system) (v) Basic Laboratory Services (including national vector borne disease programs), in-house or out-sourced (The presence of diagnostic equipment {including microscope and centrifuge} and diagnostic supplies and reagents. If claimed to outsourced, a copy of the outsourcing agreement including payment or fee schedule)] **March 2017** 50% of UPHCs meet NUHM minimum requirements for staffing and service package as a percentage of UPHCs approved for NUHM financing **March 2018** 60% of UPHCs meet NUHM minimum requirements for staffing and service package as a percentage of UPHCs approved for NUHM financing **March 2019** 70% of UPHCs meet NUHM minimum requirements for staffing and service package as a percentage of UPHCs approved for NUHM financing		
DLI 4 Community processes improved	**Prior Result** *Guidelines for ASHA and MAS in the Urban Context* are disseminated at the state level and oriented on to the state nodal officers.	MOHFW, once	1. Upon loan effectiveness, MOHFW will provide ADB with the copy of the *Guidelines for ASHA and MAS in the Urban Context* and evidence of its dissemination to the state nodal officers (e.g. the dissemination workshop held in August 2014).

Disbursement-Linked Indicator	Definition and Description of Achievement and Verification Timeframe	Information Source and Frequency	Verification Agency and Procedure
			2. ADB will verify publication of the guidelines on NUHM or NHSRC website and evidence of its dissemination to state nodal officers.
	March 2015 Training modules based on the *Guidelines for ASHA and MAS in the Urban* Context are issued by MOHFW and translated into Hindi and some local languages for use in training-of-trainers at state levels. These training modules will be: (i) ASHA induction module with urban-specific training on health vulnerability assessment; household mapping and listing; and (ii) MAS training modules.	MOHFW, one-time, until further modifications are envisaged.	1. By 1 May 2015, MOHFW will provide ADB with the copy of the Training modules based on the *Guidelines for ASHA and MAS in* the Urban Context in at least one local language to be used in training of trainers. 2. By September 2015, ADB will verify if the training modules are available in at least one local language to be used in training-of-trainers.
	March 2016 (i) 15,000 of recruited ASHAs trained in the induction module. (Approximately 40% of the targeted number of ASHAs i.e. 38,720, as per the NUHM Implementation Framework). (ii) 80% of recruited ASHAs are functional. **March 2017** (i) 23,000 of recruited ASHAs trained in induction module. (Approximately 60% of the targeted number of ASHAs i.e., 38,720, as per the NUHM Implementation Framework). (ii) 85% of recruited ASHAs are functional. **March 2018** (i) 31,000 of recruited ASHAs trained in induction module.	NUHM MIS and ASHA MIS, annual	For verification of this DLI from 2016 to 2019: 1. By 1 May of each year, State Missions will report ASHA statistics (selected, trained, drop out status, as well as sex-disaggregation) as of 31 March of the same year to MOHFW in a compiled form. (In case male workers have been assigned the role of ASHAs as per need of the state, to address the needs of the urban male population, the NUHM MIS will be updated to collect yearly information on their recruitment and functional effectiveness.) 2. By 1 July of each year, MOHFW will provide ADB with a report certifying (i) the number of recruited ASHAs who completed training using the induction module; and (ii)

Disbursement-Linked Indicator	Definition and Description of Achievement and Verification Timeframe	Information Source and Frequency	Verification Agency and Procedure
	(Approximately 80% of the targeted number of ASHAs i.e., 38,720, as per the NUHM Implementation Framework). (ii) 90% of recruited ASHAs are functional. **March 2019** (i) 35,000 of recruited ASHAs trained in induction module. (Approximately 90% of the targeted number of ASHAs i.e., 38,720, as per the NUHM Implementation Framework). (ii) At least 90% of recruited ASHAs are functional. **[Definition of being functional**, as per drop out criteria in *Guidelines for ASHA and MAS in the Urban Context*, page 8) ASHAs who have not been declared as "drop-outs". Drop out is defined as: (i) She has submitted a letter of resignation to the city/district Urban ASHA Selection Committee and to the designated ASHA Facilitator/Community Organizer for her [designated][allocated] area; **or** (ii) She has not attended three consecutive Urban Health and Nutrition Days or outreach sessions and has not given reasons for the same; **or** (iii) She has not been active in most of the activities of and ASHA facilitator/community organizer has visited the slum cluster of ASHA and ascertained through discussions with all MAS members that she is indeed not active.]		percentage of total ASHAs functional. 3. By September of each year, ADB will review the MOHFW certified reports and confirm if the targets are met.
Output 2: Quality of urban health services improved			
DLI 5 Effective system of quality assurance for urban health services	**Prior Results** *MOHFW Operational Guidelines on Quality Assurance in Public Health Facilities* are issued and disseminated	MOHFW, once	1. Upon loan effectiveness, MOHFW will provide ADB with the copy of approved operational guidelines and a record of proceedings of the National Convention on Quality in Public Health in November 2014, when the Guidelines were officially

Disbursement-Linked Indicator	Definition and Description of Achievement and Verification Timeframe	Information Source and Frequency	Verification Agency and Procedure
implemented			disseminated. 2. ADB will verify publishing of the guidelines on NUHM or NHSRC website and the record of meeting proceedings.
	May 2015 QA Assessor Guidebook and tools for UPHCs developed, reflecting MOHFW operational guidelines. [**Quality assurance tool** would include (these criteria are in line with the Guidelines on quality of public health facilities issued by the Ministry) a) areas of concern, standards and measurable elements applicable to UPHCs and UCHCs including outreach; b) protocols for internal assessment, independent assessment, state and national level certification, periodic surveillance and re-validation for certification; c) Patient/Client Satisfaction Survey, with sex-disaggregated analysis to inform men or women specific issues for further improvement.	MOHFW, once	1. By 1 July 2015, MOHFW will provide the copy of the UPHC QA Assessor Guidebook approved by MOHFW for consultation with stakeholders. 2. By September 2015, ADB will verify the finalized assessor guidebook published on NUHM or NHSRC website.
	March 2016 (i) 15 states/UTs/large ULBs have set up organizational arrangements for QA of health facilities, that include UPHCs and UCHCs Organizational arrangements for QA include monitoring and reporting mechanisms. (ii) 50% of UPHCs and UCHCs in those states/UTs /ULBs are assessing the quality of services including client/patient satisfaction. [**Large ULBs** are defined as those which have a direct responsibility for implementing NUHM and have	MOHFW, annual	1. By 1 May 2016, MOHFW will provide ADB with a report certifying: (i) that 15 states/UTs/ULBs have set up organizational arrangements and for QA of health facilities that include UPHCs and UCHCs; and (ii) that at least 50% of UPHCS and UCHCs in those locations are assessing the quality of services against set benchmarks that includes patient/client satisfaction. MOHFW report will include: (i) state/UT/ULB specific details of organizational

Disbursement-Linked Indicator	Definition and Description of Achievement and Verification Timeframe	Information Source and Frequency	Verification Agency and Procedure
	a dedicated City Project Management Unit.]		arrangements; and (ii) total number of UPHCs and UCHCs and the percentage in these areas which have been assessed. 2. By July 2016, MOHFW and ADB will conduct a joint field validation of the state/UT/ULB specific reports (sample based). 3. By September 2016, ADB will verify if the DLI targets met.
	March 2017 (i) 20 cumulative states/UTs/large ULBs have set up organizational arrangements for QA of health facilities, that include UPHCs and UCHCs (ii) 80% of UPHCs and UCHCs in those states/UTs /ULBs are assessing the quality of services including client/patient satisfaction.	MOHFW, annual	1. By 1 May 2017, MOHFW will provide ADB with a report certifying: (i) that 20 states/UTs/ULBs have set up organizational arrangements and for QA of health facilities that include UPHCs and UCHCs; and (ii) that at least 50% of UPHCS and UCHCs in those locations are assessing the quality of services against set benchmarks that includes patient/client satisfaction. MOHFW report will include: (i) state/UT/ULB specific details of organizational arrangements; and (ii) total number of UPHCs and UCHCs and the percentage in these areas which have been assessed. 2. By July 2017, MOHFW and ADB will conduct a joint field validation of the state/UT/ULB specific reports (sample based). 3. By September 2017, ADB will verify if the DLI targets met.

Disbursement-Linked Indicator	Definition and Description of Achievement and Verification Timeframe	Information Source and Frequency	Verification Agency and Procedure
	March 2018 (i) 40% of UPHCs and UCHCs in the 20 states/UTs/ULBs received national or state-level quality certification; (ii) MOHFW conducted a comprehensive, independent review of the QA program with states focusing on (a) the quality of urban primary health care services, and (b) effectiveness of quality assurance mechanism **March 2019** Based on the review MOHFW prepared and approved a time-bound action plan to further improve: (a) quality of urban primary healthcare services; and (b) quality assurance mechanism.	MOHFW, once Independent evaluation report, once Time-bound action plan, once	1. (i) By 1 May 2018, MOHFW will certify the total and percentage of UPHCs and UCHCs in the 20 states/UTs/ULBs having received national- or State-level certifications. MOHFW will include an enumerated list of the certified facilities and their details and (ii) by 1 July 2018, MOHFW will provide ADB with the report of the QA program review. 2. By September 2018, ADB will verify if the DLI targets are met 1. By 1 March 2019, MOHFW will submit the action plan to ADB, and ADB will verify the adequateness of the action plan in addressing issues and recommendations identified by the independent evaluation report.
Output 3: Capacity for planning, management, and innovation and knowledge sharing strengthened			
DLI 6 Planning, management and monitoring capacity to deliver urban health services strengthened	*a. Program Management Capacity* **Prior Result** At least 30% of staff sanctioned for NUHM at SPMUs, DPMUs and CPMUs are in position. [SPMUs, DPMUs and CPMUs will include, but not limited to, program manager, accounting/finance, M&E/HMIS/MIS, and procurement functions.]	NUHM MIS, once NUHM MIS	1. Upon loan effectiveness, MOHFW to provide the following information from NUHM MIS before submitting the first withdrawal application for disbursement against prior results: (i) Number of the staff sanctioned for NUHM SPMUs, DPMUs, and CPMUs approved as of 31 March 2014. (ii) Number of the sanctioned staff that are in position by loan effectiveness or earlier (with a list of breakdown by SPMU, DPMU and CPMU). . (iii) 2. ADB will review and confirm the

Disbursement-Linked Indicator	Definition and Description of Achievement and Verification Timeframe	Information Source and Frequency	Verification Agency and Procedure
			achievement of results based on the provided information. ADB will visit 5 randomly selected states to assess program management capacity.
	March 2015 (iii) The National Program Management Unit is supported by experts in planning, management, monitoring, and other technical areas to assist (a) MOHFW in managing NUHM and overseeing implementation, and (b) states/UTs/ULBs in program implementation	MOHFW, once	1. By 1 July 2015, MOHFW to provide ADB with a detailed report on the NPMU capacity in management of NUHM. 2. By September 2016, ADB will review the report and verify the adequacy of NPMU capacity.
	March 2016 (i) At least 55% of staff sanctioned for NUHM at SPMUs, DPMUs and CPMUs are in position.	NUHM MIS	1. By 1 July 2016, MOHFW to provide ADB the following information from NUHM MIS: (i) Number of the staff sanctioned for NUHM SPMUs, DPMUs, and CPMUs approved as of 31 March 2014. (ii) Number of the sanctioned staff that are in position by May 2016 or earlier (with a list of breakdown by SPMU, DPMU and CPMU). 2. By September 2016. ADB will review and confirm the achievement of results based on the provided information. ADB will visit 5 randomly selected states to assess program management capacity
	b. Capacity Development **March 2015** (i) MOHFW will develop and approve a costed capacity development framework [**A capacity development framework** may include the following aspects, but not limited to:	MOHFW, once	1. By 1 July 2015, MOHFW will provide ADB with the capacity development framework approved by MOHFW. 2. By September 2015, ADB will review the

Disbursement-Linked Indicator	Definition and Description of Achievement and Verification Timeframe	Information Source and Frequency	Verification Agency and Procedure
	a. Comprehensive human resource development plan for managerial and technical personnel; b. Strengthening existing national and state entities to support urban health, c. Provision of technical and management support to MOHFW and states, especially lagging ones, through a pool of experts and a demand-based consulting inputs through indefinite service delivery d. Enhancing knowledge, training, and institutional capacity in urban health through organization of international and national forums, twining arrangements between schools of public health in India and abroad, and a new dedicated institute for urban health research and training. The capacity development framework would specify : a. Priority areas for capacity development, including planning, financial management, procurement, and monitoring and evaluation for improved business process; b. NUHM financial support for capacity building at the state- and city-levels: 1. eligible areas of support and norms for funding; and 2. implementation procedures – proposal submission, appraisal, approval, and fund disbursal. c. Monitoring and evaluation – result areas, performance indicators, targets to be committed by states/ cities, and reporting mechanism.] (ii) HMIS includes urban disaggregated data, and has the functionality to identify urban health facilities serving in or in close proximity to slums, resettlement areas, and vulnerable populations.	MOHFW, annual	framework and verify the elements of the capacity development framework. 1. By 1 July 2015, MOHFW will provide ADB with a report certifying fully disaggregated urban data, and HMIS will have functionality to identify urban health facilities serving in or in close proximity to slums, resettlement areas, and vulnerable populations. 2. By September 2015, ADB will review and verify the report and check the HMIS functionality to identify urban health facilities in or close to slums, resettlement areas and vulnerable populations.

Disbursement-Linked Indicator	Definition and Description of Achievement and Verification Timeframe	Information Source and Frequency	Verification Agency and Procedure
	March 2016 (i) MOHFW's review of NUHM capacity development framework shows progress at national level and in 15 states/UTs: a. (1) increased staff numbers/capacity in urban health in national and state technical agencies, (2) conducting trainings in health service delivery and program management; b. strengthened M&E system, including (1) adapting NRHM MIS format for NUHM, (2) expanding reporting of HMIS by facilities, (3) training data entry operators and data administrators in data quality, (4) community process data collected under ASHA MIS; and c. monitoring and reporting of availability and quality of essential drugs in UPHCs and UCHCs.	MOHFW, annual	1. By 1 July 2016, MOHFW will provide ADB with a report reviewing the progress achieved by NUHM in the capacity development framework implementation as defined in the verification protocol. 2. By September 2016, ADB will review and verify the review report.
	March 2017 MOHFW's independent evaluation of NUHM capacity development framework shows progress at national level and in 20 states/UTs: a. (1) increased staff numbers/capacity in urban health in national and state technical agencies, (2) conducting trainings in health service delivery and program management; b. strengthened M&E system, including (1) adapting NRHM MIS format for NUHM, (2) expanding reporting of HMIS by facilities, (3) training data entry operators and data administrators in data quality, (4) community process data collected under ASHA MIS; and c. monitoring and reporting of availability and quality of essential drugs in UPHCs and UCHCs.		1. By 1 July 2017, MOHFW will provide ADB with an evaluation report by an independent evaluator to assess the implementation of NUHM capacity development framework as per verification protocol. 2. By September 2017, ADB will review the report and verify if the targets (at least 60% of annual targets achieved at national level and in 20 states/UTs in priority areas) are met.
	March 2018 Based on recommendations of the independent evaluation (conducted in 2017), MOHFW has revised the NUHM capacity development framework,	MOHFW, once	1. By 1 July 2018, MOHFW will provide ADB with a revised capacity development framework.

Disbursement-Linked Indicator	Definition and Description of Achievement and Verification Timeframe	Information Source and Frequency	Verification Agency and Procedure
	including outputs and modalities		2. By September 2018, ADB will confirm if the revised framework is published on NUHM or NHSRC website.
	March 2019 NUHM capacity development framework (updated) implementation achieved at least 75% of annual targets at national level and in 25 states/UTs in priority areas	MOHFW, once	1. By 1 July 2019, MOHFW will provide ADB with a report of implementation of the revised capacity development framework. 2. By September 2019, ADB will confirm if the targets are met.
DLI 7 Innovations and partnerships in urban health developed, tested and shared	**March 2016** A framework for innovations and partnerships, including examples of good practices, is developed, approved, and implemented. [NUHM framework for innovations and partnerships will specify: • overall objectives of innovations and partnerships; • eligible areas of innovation and partnerships, focusing on 'processes' (such as convergence, PPP) and 'products' (such as ICT and medical technology) • mechanisms of knowledge sharing ; • financial and technical support under NUHM; and • guidelines for determining and documenting good practices.]	MOHFW, once	1. By 1 May 2016, MOHFW will provide a copy of Framework for Innovations and Partnerships. 2. By 31 September 2016, ADB will review adequacy of the framework meeting the criteria described in the definition in verification protocol and verity if the framework is published on NUHM website and at least one activity in knowledge sharing is conducted.
	March 2017 50% of states/UTs/large ULBs implement innovations and partnerships aiming at improving equitable access to or quality of urban health services. [**Large ULBs** are defined as those which have a direct responsibility for implementing NUHM and have a dedicated City Project Management Unit.]	MOHFW, once	1. By 1 July 2017, MOHFW will certify the percentage of States/UTs/large ULBs implement innovations and partnerships aiming at improving equitable access to or quality of urban health services. The MOHFW report will include a list of States/UTs/large ULBs and details of their innovations and partnerships.

Disbursement-Linked Indicator	Definition and Description of Achievement and Verification Timeframe	Information Source and Frequency	Verification Agency and Procedure
			2. By September 2017, MOHFW and ADB will jointly review and verify from a sample of the submitted list of innovations and partnerships. Independent review by the entity engaged by ADB under the piggy-backed TA as required.
	March 2018 20 Good practices in innovations and partnerships in at least 10 states/UTs/large ULBs are demonstrated and disseminated.	MOHFW, once	1. By 1 July 2018, MOHFW will submit the list of 20 good practices in innovations and partnerships in at least 10 states/UTs/large ULBs. The MOHFW report will include details of their demonstration and dissemination. 2. By September2018, MOHFW and ADB will jointly review and verify from a sample of the list of good practices. Independent review by the entity engaged by ADB under the piggy-backed TA as required.
	March 2019 Incentive mechanisms developed and approved for implementation in FY2020 for more innovation for equitable access to, and improved quality of, urban health services including performance based financing	MOHFW, once	1. By March 2019, incentive mechanisms such as performance based financing, matching fund scheme, etc. are developed and approved by MOHFW for implementation in FY 2020 to encourage innovations and replication / expansion of proven innovative approaches for better quality of and equitable access to urban health services

ADB = Asian Development Bank, ANM = auxiliary nurse midwife, ASHA = accredited social health activist, CPMU = city program management unit, DLI = disbursement-linked indicator, DPMU = district program management unit, HMIS = health management information system, JSY = Janani Suraksha Yojana, MAS = Mahila Arogya Samitis, M&E = monitoring and evaluation, MIS = management information system, MOHFW = Ministry of Health and Family Welfare, NRHM = National Rural Health Mission, NUHM = National Urban Health Mission, PIP = program implementation plan, SPMU = state program management unit, ULB = urban local body, UPHC = urban primary health center, UCHC = urban community health center, UT = union territory.
Source: Asian Development Bank

Table A3: Expected Disbursement Schedule

Disbursement-Linked Indicators	Total ADB Financing Allocation ($ million)	Share of Total ADB Financing (%)	Financing for Prior Result ($ million)	2015 ($ million)	2016 ($ million)	2017 ($ million)
DLI 1 Increased institutional delivery in urban areas	30	10	—	—	15	15
DLI 2 Increased complete immunization among children below 12 months of age in urban areas	30	10	—	—	15	15
DLI 3 City-specific primary health care delivery system established	65	22	(i) 5 (ii) 5	15	(i) 10 (ii) 10	20
DLI 4 Community processesimproved	55	18	10	15	(i)10 (ii) 5	(i)10 (ii) 5
DLI 5 Effective system of quality assurance for urban health services implemented	55	18	10	15	(i)10 (ii) 5	(i)10 (ii) 5
DLI 6 Planning, management and monitoring capacity to deliver urban health services strengthened	45	15	10	(i) 5 (ii) 5 (iii) 5	(i) 5 (ii) 5	10
DLI 7 Innovations and partnerships in urban health developed, tested and shared	20	7	—	—	10	10
Total	**300**	**100**	**40**	**60**	**100**	**100**

ADB = Asian Development Bank, DLI = disbursement-linked indicators
Source: ADB

ANNEX 3

STATEMENT OF AUDIT NEEDS

A. Background

1. Asian Development Bank (ADB) and the Government of India have entered into a Loan Agreement whereby, ADB shall provide US$500 million for the purpose of financing IND 47354: Supporting National Urban Health Mission (NUHM) in all states/union territories (UTs) in India. In the first 3 years, ADB shall provide US$300 million and in the next 2 years US$200 million as additional financing. The program modality for ADB's support is results-based lending (RBL), which means that the financial management (FM) system of the Government of India and states/cities will be used for implementation. The Program will be carried out adapting the existing implementation arrangements of National Rural Health Mission (NRHM). State Health Society (SHS) at the state level, District Health Society (DHS) at the district level and (new) City Urban Health Society (CUHS) in case of some cities, especially the 7 mega cities, will be involved in implementation at sub-national level. Thus, SHS, DHS and CUHS (implementing agencies [IAs]) shall maintain accounts and records with respect to this Program, including all items of expenditure financed out of the proceeds of the loan agreement as per their existing systems and practices.

2. As a part thereof, ADB shall be requesting the submission of audited annual consolidated financial statements of the program by each states/UTs prepared in accordance with international best practices in auditing and financial reporting.[30]

B. Program Development Objectives

3. The Program is designed to support sustainable and quality urban health delivery system targeting the needs of urban poor and vulnerable sections in all states/UTs in India. The program outputs are given in detail in the Report and Recommendation of the President to the Board of Directors.

C. Financial Reporting and Audit Requirements

4. Each of the 35 SHSs will prepare Consolidated Program Financial Statements based on financial information provided by the DHS and CUHS including program-wise Statement of Expenditure on a cash basis (apart from other corresponding schedules and statements as per the Ministry of Health and Family Welfare (MOHFW)'s 2012 "Operational Guidelines for Financial Management" under NRHM), which is in accordance with the General Financial Rules (GFR), 2005, in General and Accounting Policies prescribed in the "Operational Guidelines for Financial Management" in particular. The consolidated financial statements covers all vertical programs implemented by the SHS, including NUHM, expenditure against each of which is identifiable in the audited program financial statements (APFS).

5. **Statutory (External) Audit.** The statutory audit of the program financial statements at the state level shall be carried out by independent firm of Chartered Accountants (CA) empanelled with the Comptroller and Auditor General (CAG) and appointed by the SHS, in accordance with the Auditing Standards issued by the Institute of Chartered Accountants of India (ICAI) in general and the Audit Checklist as per the MOHFW's 2012 "Operational Guidelines for Financial Management" under NRHM) in particular, as supplemented by this

[30] Throughout this document, consolidation refers to the consolidation of various vertical programs by each SHS.

Statement of Audit Needs (SoAN). The CAG may undertake supplementary external audit of the IA in addition to the audit conducted by the CA firm auditor, in accordance with the CAG Indian Auditing Standards (CAG has adopted its auditing standards which are adapted from the International Organization of Supreme Audit Institutions [INTOSAI] 2009 Auditing Standards). The private auditor will review that the funds received from all sources and expenditure incurred during the reporting period are as per agreed terms and conditions of the program implementation plan (PIP). This will include all expenditure of the IA and activities in supporting this Program.

6. Each SHS is required to submit to Government of India − MOHFW APFS as of 31 March of each financial year, within 4 months of the end of the fiscal year in English, i.e., 31 July, although delays are historically encountered and all APFS are received by December. The primary objective of statutory audit is to ensure that the financial statements, i.e., the Balance Sheet, Income & Expenditure Account and Receipt & Payment Account, give a true and fair view and are free from any material misstatements. The statutory audit also aims at ensuring that the respective program expenditures are eligible for financing under the relevant grant/ credit agreements (under programs supported by development partners) and that the funds have been utilized for the purpose for which they were provided. A complete set of audited program financial statements as given in the financial management group (FMG) Operational Guidelines includes:

(i) Audit opinion (as per the format prescribed in NRHM guidelines)
(ii) Consolidated audit report and individual reports on all programs (as schedules)
(iii) Percentage of coverage of districts and blocks by auditor mentioned in report
(iv) Completed checklist attached
    a. Audit checklist
    b. Management letter checklist (as per the format prescribed in NRHM guidelines)
(v) Following completed financial statements in the latest approved format
    a. Balance Sheet
    b. Income and Expenditure
    c. Receipts & Payment
(vi) Statement of Reimbursable Expenses
(vii) Following other relevant schedules/ documents in the latest approved formats
    a. Unspent grants of individual programs
    b. Capital Fund
    c. Current Liabilities
    d. Fixed Assets
    e. Loans and Advances (party wise and age wise analysis)
    f. Cash and Bank Balances
    g. Program wise Statement of Expenditure
    h. Bank Reconciliation Statement
    i. Scheme wise Certified Utilization Certificates
    j. Audited FMRs
(viii) Reconciliation between expenditure as per FMR and audit report
(ix) Notes to Accounts
(x) Accounting Policies
(xi) Comment on compliance with previous year’s audit observations
(xii) Representation by Management
(xiii) Management Letter

7. The audited program financial statements of states/UTs along with their Audit Reports and Management Letters shall be submitted to ADB within 9 months of the end of the fiscal year, i.e., by 31 December of each year.

8. In addition to the above, the FMG unit shall also submit to ADB annually a Certificate of Compliance , confirming that eligible expenditure incurred during the fiscal year, and cumulative from commencement of the program to date exceed total disbursements from ADB. Eligible expenditure refers to all non-procurable items (salaries, utilities, etc.) and procurements from ADB-member countries less (i) high value contracts and (ii) expenditure on civil works with potential safeguard (Indigenous People and Involuntary Resettlement) implication as identified through the two-stage safeguard screening process, if any. Such certificate shall be accompanied by a consolidated breakdown of such eligible expenditure by cost category.

D. Specific Audit Needs

9. The audit would cover the entire Program, i.e. covering all sources and application of funds, including the ADB, co-financiers and the Government of India / State as well as direct payments and grants in kind, if any. The Mission Director (MD) at the state level shall provide all pertinent information to the Auditors including preservation and use of resources procured and its reflection in the program accounts, so as to facilitate comprehensive audit coverage. The audits should be carried out annually from commencement of the Program.

10. The auditor will provide reasonable assurance as to whether the program financial statements present a true and fair view of the receipts and expenditures, or are presented fairly, in all material respects, in accordance with the applicable financial reporting framework. The auditor will also provide assurance as to whether (i) financial covenants of the loan agreement have been complied with, and (ii) loan proceeds have been used for the purposes intended

11. ADB would need a review of actions taken on the recommendations presented in the previous audit report on the progress made.

12. Management Letter - Serious issues affecting the auditor's opinion as to whether the financial statements give a true and fair view, should be referred to in the audit opinion itself. Matters that are not material and do not affect the true and fair representation of the project financial statements should not be referred to in the audit opinion and included therein. A separate management letter may be issued for this purpose. The auditor may wish to re-iterate serious issues already identified in the audit report, in his management letter clearly indicating that the weaknesses identified during this course of examination though not material but are included in this management letter are relevant for further improvement in overall operations of the entity. Auditors are encouraged to clearly segregate the management letter, and mark the management letter as 'confidential', to enable its easy separation from the audit opinion and project financial statements, and prevent inadvertent disclosure of the management letter along with the APFS.

E. Program Financial Statements

13. Templates for financial statements are provided in the MOHFW's 2012 "Operational Guidelines for Financial Management" for NRHM.

14. In addition to the existing disclosure and audit requirements of NHM, ADB will also require:

(i) A disclosure in financial statements/ Auditor's Report of the fact that ADB is providing funds for implementation of NUHM; If this is any non-compliance with the loan covenants, then this should be disclosed in the Audit Report.

(ii) In cases where the Grantee has received medicines, consumables, equipment, etc. without any payment, the same needs to be valued and disclosed in the accounts. Grants which can be valued or measured should be recognized and those which cannot be objectively recognized should be disclosed. Valuation of grants in kind needs to be valued as per para. 12 of the Indian Government Accounting Standard (IGAS) 2 and disclosed as per para. 20 of the same IGAS.

(iii) The Accounting Policy would state that financial statements are prepared based on the NHM's "Operational Guidelines for Financial Management and Indian Government Accounting Standards". Once the financial statements are made compliant to International Public Sector Accounting Standards, a fact of the same may also be mentioned.

(iv) The annual financial statements should have a statement for budget vs actuals for the entire year with % variance.

(v) The annual financial statements should include a note stating "These financial statements were approved by [insert governing body] on [insert date]".

F. General

15. Review missions and normal program supervision will monitor compliance with financial reporting and auditing requirements and will follow up with concerned parties, including the external auditor.

16. ADB has made IA aware of ADB's approach on delayed submission, and the requirements for satisfactory and acceptable quality of the audited financial statements.[31] ADB reserves the right to require a change in the auditor in a manner consistent with the constitution of the borrower, or for additional support to be provided to the auditor, if the audits required are not conducted in a manner satisfactory to ADB, or if the audits are substantially delayed.

17. ADB retains the right to verify or have audited (i) the program, (ii) the validity of IA's certification for each withdrawal application, and (iii) that ADB's financing is used in accordance with ADB's policies and procedures.

[31] ADB approach on delayed submission of audited project financial statements:
- When audited project financial statements are not received by the due date, ADB will write to the executing agency advising that (i) the audit documents are overdue, and (ii) if they are not received within the next 6 months, requests for new contract awards and disbursement such as new replenishment of imprest accounts, processing of new reimbursement, and issuance of new commitment letters will not be processed.
- When audited project financial statements are not received within 6 months after the due date, ADB will withhold processing of requests for new contract awards and disbursement such as new replenishment of imprest accounts, processing of new reimbursements, and issuance of new commitment letters. ADB will (i) inform the executing agency of ADB's actions; and (ii) advise that the loan may be suspended if the audit documents are not received within the next 6 months.
- When audited project financial statements are not received within 12 months after the due date, ADB may suspend the loan.

18. In case an external auditor needs to be commissioned for a supplementary audit, the auditor should be given access to all legal documents, correspondences, and any other information associated with the commission and deemed necessary by the auditor. Confirmation should also be obtained of amounts disbursed and outstanding with ADB and the Government, etc.

G. Public Disclosure

19. Public disclosure of the program financial statements, including the audit report on the program financial statements, will be guided by ADB's Public Communications Policy (2011).[32] After review, ADB will disclose the program financial statements for the program and the opinion of the auditors on the financial statements within 30 days upon date of their receipt by posting them on ADB's website. The Audit Management Letters contain proprietary information intended solely for the needs of the management and will not be disclosed.

Note: This is a statement of audit needs for ADB and does not in any way intend to limit the scope of the statutory audit.[33]

[32] Available from http://www.adb.org/documents/pcp-2011?ref=site/disclosure/publications.

[33] SOAN was explained to the FMG during the fact finding mission of the proposed program, and a copy shall be shared by the FMG with each State auditor through the SHS prior to commencement of the audit.