ROYAL GOVERNMENT OF BHUTAN

ACCELERATING MATERNAL AND CHILD HEALTH OUTCOMES PROJECT (AMCHP)

PROJECT OPERATIONS MANUAL
Part 1: Project Administration

MINISTRY OF HEALTH

Version 1

[WB No Objection: December 6, 2024]

JSDF
Japan Social Development Fund

ACRONYMS

MNCH	Maternal, Neonatal and Child health
MOH	Ministry of Health
TIS	Tracking Information System

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I. INTRODUCTION

A. Project description

Bhutan has made significant progress improving human capital but still has a long way to go to realize its full potential. According to the Human Capital Index 2020, a child born today in Bhutan will be only 48 percent (and with the COVID-19 pandemic this index may have further declined in recent years) as productive in adulthood as they could have been with a complete education and better health care. Before the COVID-19 pandemic, the observed human capital gains in the form of reduced stunting and child mortality and improved educational outcomes reflected the RGOB's investments to expand the coverage and improve the quality of health and education services.

The benefits of these gains, despite large and free education and health system, however, have not been equally distributed both in terms of geography and across income quintiles. Access to maternal and child health and nutrition services, early childhood care and development (ECCD), quality education, and skills training that would improve the transition from birth to school to work, are worse in remote and rural locations, and among poorer households. On maternal, neonatal and child health (MNCH), Dorji et al (2019) shows that antenatal care and institutional birth delivery are much lower in the rural and remote areas of the country, and among women with lower levels of education and lower socioeconomic status.

Furthermore, the COVID-19 pandemic disrupted provision and utilization of essential services, such as antenatal care which dropped from 82 to 76 percent for four visits and from 54 to 25 percent for eight visits. According to the past five Annual Health Bulletins (AHB), 2018-2022, the percentage of women that had first antenatal care visit during the first trimester of pregnancy increased from 44.8 percent to 48 percent, then to 54 percent; but since COVID-19 pandemic, it has decreased to 53.3 percent and bounced back to 54.7 percent. Similar pattern was observed for postnatal care: completing 2 or move visits increased from 79 to 85.8 and then to 88.6 percent, but post COVID-19, it has decreased to 76.5 percent, and bounced back to 80.7 percent. Finally, maternal mortality ratio increased from 86 to 89 per 100,000.

Consequently, providing comprehensive and quality maternal and child healthcare in the country is a national priority. In the 12th Five Year Plan (2018-2023), targets for maternal and child health constitute some of the most important components of the National Key Result Areas (NKR-A). Furthermore, Bhutan is also committed to the global Sustainable Development Goals (SDGs) which include specific targets for maternal, neonatal and child health (MNCH).

In order to accelerate improvements in MNCH outcomes, improved utilization of health services has been identified as a key strategy under the Comprehensive . Demand-side programming, which includes, inter alia, the provision of incentives, has been successful in many settings.

Under Bhutan's Accelerating Maternal and Child Health Outcomes Project (AMCHP), similar demand-side programming is proposed, in an effort to improve utilization of target maternal and child health services. Specifically, a conditional cash transfer (CCT) program will provide certain monetary incentives to selected pregnant and lactating women with children under 2 years old (PLW) in Bhutan who avail the requisite MNCH services. The overarching aim, in so doing, is to accelerate improvements in MNCH outcomes.

The project will address PLW's inequalities of opportunities and the financial burden among socially economically and vulnerable PLW, which are linked to out-of-pocket costs that are significant barriers to accessing health care, such as costs associated with transportation (e.g., three times higher in rural

areas as compared to urban) or to loss of daily wages/workdays. As women face competing household priorities (household chores and farm work take precedence over seeking health care), negative social and cultural norms, family pressure and health illiteracy, the project will promote social mobilization, social and behavior change communications (SBCC) activities to all PLW across the country to increase their awareness and knowledge about parenting, childcare, nutrition and early stimulation. In addition, eligible ones (i.e., socially, and economically vulnerable) will receive conditional cash transfers (CCTs) linked to utilization of MNCHN services. The two activities are designed to increase the Golden 1,000 Days outcomes in Bhutan by addressing existent demand side barriers for utilizing and benefiting from existing supply of MNCHN services available nationwide.

The innovative aspects of the project build on promoting strong collaboration between Social Protection and Jobs and Health sectors guided by the international experience to help Bhutanese families make better human capital investments. Moreover, benefiting from the current banking landscape and IT accessibility/connectivity of Bhutan, the project will promote the use of disruptive technologies to facilitate electronic transactions through banks and to have better communications between community leaders, health workers and beneficiaries, and the project can serve as an initial platform for broader provision of services to socially economically and vulnerable ones in the country in order to improve human capital and reduce vulnerabilities, including against shocks.

AMCHP is financed by the World Bank via a Grant from the Japan Social Development Fund (JSDF) provided by the Government of Japan.

B. Project development objective (PDO)

The PDO is to enhance utilization of maternal, neonatal, child health and nutrition services (MNCHN) by pregnant and lactating women (PLW) in all districts of Bhutan.

C. Project beneficiaries

The project's main beneficiary population is the PLW participating in the MCHP, nevertheless only the economically and socially vulnerable PLW will be selected for the CCT activity. Moreover, throughout its implementation the project will build capacity of MOH staff, Health care providers, Local Government leaders.

D. Project components

(a) Component 1: Increasing Utilization of Essential MNCHN Services

This component will:

- Provide social and behavior change communications (SBCC) support at the national, facility, community and household levels through information, education and communication, and social mobilization.
- Provide conditional cash transfers (CCTs) to eligible socially and economically vulnerable PLW.
- Provide training to key stakeholders on SBCC and CCTs, to improve knowledge and awareness of MCHP, including: (i) the roles and responsibilities of Beneficiary, health facilities, local government (LG), and MOH staff; and (ii) grievance redress channels.

More specifically, SBCC will be offered to the PLW and other family members (including the fathers) on a regular basis as described in the project operations manual (POM). SBCC would be carried at the national, health facility, community and household levels. PLWs will be mobilized through massive communication activities, during MNCHN visits, during routine outreach clinics (OCR) activities, and

through sensitization activities organized by local government officials from the three government levels (Dzongkhas, Geowg, and Chiwog) to participate in counseling and awareness sessions on health visits, birth spacing, hygiene, feeding and caring practices, financial and digital literacy, as well as food security, dietary diversity and strategies to cope with climate induced risks. The providers and community leaders involved in SBCC would be trained and armed with materials and tools.

CCTs will be provided to selected socially and economically vulnerable PLW. Monthly and directly electronic transfers of BTN 1,500 (about US$18) to selected PLW bank accounts during the Golden 1,000 days period (maximum for 33 months) aims at boosting utilization of services among those more vulnerable PLW.

CCT eligibility will be determined at the public health facility during the PLWs registration in the TIS. All women provided they have been confirmed pregnant following their first registration at a public health unit, and all women currently registered as mother of a child under 2 years of age in the MOH District Health Information Software 2 (DHIS2) are eligible for CCT if their estimated welfare of the household obtained through a Proxy Means Testing approach is below the cut-off point.
CCT co-responsibilities or conditionalities includes regular health checkups of eligible PLWs, institutional delivery and birth registration, child growth monitoring and promotion, and immunization of children under two years of age. Full details on the CCT implementation will be provided in the conditional cash transfer dedicated manual.

(b) Component 2: Develop Tracking Information System

This component will:

- Develop a tracking information system (TIS) to strengthen MOH information system and to facilitate administration of the MCHP at the central and district levels, including: (i) identify and track PLW service uptake and PLW compliance with CCT conditionalities, (ii) support monitoring and evaluation, and (iii) provide an accessible grievance redressal mechanism for the PLWs.
- Provide relevant training on TIS for MoH staff.

The TIS will facilitate administration and accountability of the MCHP, supporting MOH at the central and district levels to manage and communicate directly with PLW. TIS will be designed in collaboration with Government Technology Agency (GovTech), which was established in December 2022 to carry out functions related to Information, Communications and Technology in the country. The proposed system must operate online and offline, have a modular approach, use of visual tools and dashboards, and be supported by mobile app.

TIS should be interoperable with National ID system and DHIS2 (Maternal Child Health module) and later be integrated to the ePIS (Electronic Patient Information System), and consequently, contributing to the development of Digital Public Infrastructure in Bhutan. TIS will encompass, among others, the eligibility criteria, compliance, payment and grievances and redress modules.

The costs incurred by this component are only related to the development, data storage and maintenance of the TIS that will be supported by and hosted at GovTech, and associated training on using the TIS. A Memorandum of Understanding will be signed with GovTech to ensure the ownership and delineate roles and responsibilities regarding the development of TIS.

(c) Component 3: Project Management and Administration, Monitoring and Evaluation, and Knowledge Dissemination

This component will provide technical support to PMU for the day-to-day management and implementation of Project activities, including financial management, procurement, environmental

and social standards, monitoring and evaluation, and knowledge dissemination of Project results and lessons learned. This component will ensure that the Project is operational and that MOH implements the project in conformity with the Financing Agreement and the POM. This component will finance: (i) the hiring of consultants (non-civil servant) including operational costs to support implementation as needed; (ii) equipment and operating costs for MOH directly linked to the daily management of the project (e.g., utilities and supplies, communications, and travel and supervision costs); (iii) regular audits (in accordance with the Bank's legal requirements for audits of financial and procurement aspects); (iv) monitoring and evaluation; and (v) Knowledge and dissemination activities.

E. Institutional arrangements

MOH will establish a PMU at the Department of Public Health (DoPH) to manage the day-to-day activities and be responsible for the project implementation. The core members of PMU will consist of (i) DoPH public servants and contractual staff selected and paid by the project. The PMU will be composed of one at least a project director, one project manager, one expert in MNCHN, one environment and gender focal point, and one procurement and one financing management officer.

At the central level, the MOH will set up a Steering Committee, which will meet twice a year, to serve as a steering committee to oversee the implementation of the project at the national level, review progress and help addressing administrative implementation bottlenecks, if any. This Steering Committee will be chaired by the secretary of MoH and include representatives from the Ministry of Finance, Department of Local Governance and Disaster Management and Department of Health Services and National Medical Services, to oversee the implementation of the project at the national level, review progress and help addressing administrative implementation bottlenecks.

At district level, PMU will rely on the District Health Officer (DHO) for supporting the implementation of the project in the district. DHOs would help to train local government officers, as well as health providers.

At local level, PMU will rely on Local Government (LG) authorities from the three official government levels - Dzongkhags, Gewog, and Chiwog - and in alignment with the principles of strong community engagement, the LG will play an important role in the Project implementation from the Dzongkhag (district) to Chiwog (village) level. The local leaders and officials would be engaged in SBCC activities including sensitization of the Project, community mobilization, door to door visits of beneficiaries and reviewing grievances.

Due to the new organization of MOH, PMU will work closely with the National Medical Services that oversees the coverage and quality of MNCHN services at the hospitals, primary health care facilities, and ORC. Chief Medical Officers in each MNCHN service facility will support overseeing and reporting on utilization of services, while health providers that will be supported by LGs SBCC activities will be responsible for verifying the pregnancy, registering the beneficiaries, and recording services provided and visits in a timely manner.

F. Monitoring and Evaluation

The M&E of the project would focus on the implementation progress and impact of the project through a household survey, a health Service Delivery Indicator survey, as well as the TIS for the indicators at the PDO level. An M&E strategy will be developed and added to the Operations Manual once the PMU M&E expert is appointed or recruited. M&E activities would also include the annual process evaluations starting six months after the first payment is made; regular audits to assess the Project's operations and to verify utilization of the POM; regular spot checks (such as beneficiary surveys and

qualitative evaluations); one targeting assessment and one large evaluation with two rounds of data collection. M&E strategy is also expected to encompass continuous beneficiary feedback will be designed with regular engagement and a robust GRM.

Project will be monitored regularly. Main findings will be made available in the World Bank Website as part of the Implementation Status & Results Reports (ISRs). At the end of the project, the World Bank would produce an Implementation Completion Report (ICR) which would take into account MoH's own completion report.

G. Financial Management

The project will establish the PMU under the MOH responsible for the overall FM of the project. FM will rely on the Country Systems and the RGOB budgeting processes will apply. The project's budget will be part of the annual MOH budget and will be reflected in the province's Annual Development Plan and will be reflected in the province's Annual Development Plan. The annual audit report and management letter will be submitted to the Bank within six months of the close of each financial year. The project will be budgeted as part of MoH budget under a separate Financing Item Code (FIC). The activity/sub-activity codes will allow for all project-related expenditures to be separately identified, accounted, and reported in the ePEMS reports as well as in the Interim Unaudited Financial Reports (IUFRs). Clearly identifying the project components/sub-components within the ePEMS system will simplify the project financial reporting.

The project funds will be deposited in advance into the Designated Account denominated in Ngultrum to be opened at the BOB. The project will report expenditures on a quarterly basis, within 45 days from the close of each calendar quarter, in the form of "Interim Unaudited Financial Report" agreed during the negotiation. Disbursement to be made using SoEs, replenishing the funds in DA after necessary adjustments. Funds will be withdrawn from the DA on an "as required" basis and transferred to the government budget fund account (GBFA) by the by the Department of Macro-Fiscal and Development Finance as an advance. The transfers from DA to GBFA are based on requests from MoH. Based on the requests, the Department of Treasury Accounts in the MoF will release funds to the Project Letter of Credit (PLC)/Letter of credits of the MoH. MoH will issue electronic payments based on the actual payroll to be generated from the TIS.

The internal auditor of MoH will review project activities of each of the spending unit at least once every financial year but the internal audit reports will be issued on a biannual basis. These reports should be shared with the External Auditors on a regular basis and shared with the Bank during project review/supervision.

Annual audit report of the Project activities will be made available in public domain on the Royal Audit Authority website. This audit reports will also be disclosed for public review on Bank's external website as per Bank's Access to Information Policy. However, there is overdue audit or financial report under the proposed implementing agency/Ministry.

H. Procurement

Procurement under the project will be carried out in accordance with the World Bank Procurement Regulations for IPF Borrowers, Fifth Edition, September 2023 ("Procurement Regulations") and the provisions stipulated in the Project Procurement Strategy for Development (PPSD) and the procurement plan. Procurement following national market approach will use the country system subject to conditions specified in the procurement plan and agreed with the World Bank. The project will be subject to the World Bank's Anticorruption Guidelines, dated October 15, 2006, and revised in January 2011 and July 2016. The project will use the World Bank's Systematic Tracking of Exchanges in Procurement (STEP) to plan, record, and track procurement transactions.

There will be only a few procurement activities (approx. value $25,000) which will be carried out by the PMU to be set up at the DoPH under the MoH. Procurement capacity assessment shows that MoH has lack of procurement capacity although they have experience of implementing Bank financed COVID-19 emergency project. MoH has developed a PPSD along with an initial procurement plan which

spells out the overall procurement arrangement and risks and mitigation measures. Based on the assessment, residual procurement risk is 'Moderate'. More details of procurement are specified in the PPSD.

The World Bank's procurement supervision will be ensured through implementation support in the form of prior review and post review of the contracts.

I. Safeguards

Please refer to the Environmental and Social Commitment Plan for detailed description of social and environmental safeguards available at MoH website.

J. Communications

A Communication strategy will be developed to support the project to achieve its objectives. The strategy will combine General communication to stimulating the participation of father/partners/family during pregnancy, relevant documentation for CCT, importance of stimulating ANC and PNC, Comprehensive MCH program, early visit; with targeted communication to stakeholders as health workers and local leaders.

A range of material will be developed around a range of topics as Preconception; Nutrition and breastfeeding; Early visit, and Financial literacy etc.

The expected delivery mode and target audience includes

#	Delivery mode	Target audience
1	Media outlets	General public
2	Social media	General public
3	Local government leaders	General Public
4	VHWs	PLW; individual
5	ORCs	Community group
6	Sub-posts	Individual/Group
7	PHCs	Individual/Group
8	Hospitals	Individual/Group

As part of the communication, the PMU must ensure visibility for the support received by JSDF and by the World Bank. It is expected that Japan and World Bank will feature prominently in the project communications, capacity building workshops, and policy dialogue throughout the project life, in addition to press releases prepared for the project launch.

Moreover, publications, training programs, seminars, press releases and workshops organized by PMU will clearly indicate that the grant activities are funded by the Government of Japan and JSDF, and World Bank through utilization of official logos.

K. Grievance Redress Mechanism (GRM)

AMCHP has a Grievance Redress Mechanism, (GRM) which allows beneficiaries to complain and/ or seek clarification including the following:

- Lodging of grievances, claims and updates
- Grievance process and timelines at each stage

- Address the grievances
- Results of each case and notification to concerned person

The principles guiding the GRM include:

- *Transparency*: Beneficiaries should be able to access information relating to the processing of their complaint;
- *Confidentiality*: Name of the complainant, alleged person that the claim may be referring to (where applicable) and the subject-matter of the complaint should not be made public;
- *Impartiality*: Decisions should be taken after due consideration of objective parameters; and,
- *Non-retaliation*: Beneficiaries should be assured that lodging and submitting complaints will not adversely affect them. Likewise, health workers and other stakeholders involved in the program should be encouraged to view the GRM process as a way of improving program implementation.

Points of Entry

Complaints can be made at two entry points: 1) through the Local government functionaries; If a complaint and request for information is made to the LG, no record of this complaint would be lodged made in the TIS (This point of entry would therefore be useful for beneficiaries who wish to clarify certain aspects of the program, and/ or their participation in the program.

The District Health officer is responsible for answering the hotline and recording requests for information or complaints. A confirmation number is sent by SMS to the complainer´s mobile number, with a reference number, and indication of whether the complaint was resolved during the conversation, or if the complainer should expect a resolution in the coming days. In general, complaints should be resolved within 10 working days. For more complex complaints (category 5 in the table below), these should be resolved within 20 working days.

Scope and Limitation of GRM

Complaints and feedback can be received from beneficiaries, members of the communities of intervention, health facility staff, and LG.

Categorization, Processing, Resolutions of Complaints & Feedback

Complaints made by beneficiaries through the hotline can receive immediate resolution (in the case of request for information or assistance) or will need to be investigated by the DHO. The following table summarizes the main categories of complaints:

Category	Processing	Where	Resolution
1: Request for information about the AMCHP	Category 1 is resolved at entry point	At health center by health worker	All category 1 – 2 complaints and feedback are addressed immediately by the LG ,DPHO and health workers

Category	Processing	Where	Resolution
2. Missed recording/lost of data/ delayed inputs of the recording resulting	Category 1	Health worker	Health worker addresses the complaint
3: Minor complaints, for example, Health professionals not available on planned date of visit, visit seemingly not entered in the system and beneficiary not receiving confirmation of visit by SMS.	DHO to contact relevant Health professionals	With health workers	Category 3 complaints solved after contacting Health professional responsible for service provision, and/ or responsible for entering compliance data in the system.
2: Appealing against the PMT score - request to become a beneficiary of the CCT	Category 4 complaints are verified by DPHO and final decisions are made by PMU	Through TIS by health workers/GAO within 30 days Verified by DPHO Submitted to PMU with recommendation	Category 4 complaints should be solved by PMU within 20 working days
4: Complaints linked to payments: transfers not available on Bank account at due date, and any issue regarding banking operations (e.g. no cash available at ATM)	Category 3 complaints are investigated by DPHO, who will be responsible for contacting Banks.	Complaint lodge at respective Health center	Category 3 complaints should be solved within 10 working days and resolution communicated and explained to beneficiary.
5: Complaints regarding fraud of any sort, such as forceful collection of funds or solicitation of tips, by Bank employees, by community members or Health professionals, etc.	Category 4 complaints are investigated and reviewed by DHO and PMU	Lodge the complaints with GAO	Category 5 complaints like alleged staff misconduct require a thorough investigation, and should be resolved within 20 working days.

**Give special consideration for unforeseen circumstances/natural disaster/ etc.
** Communication material: have standard communication information on lodging complaint by phone call to GAO/Health workers /through Tshogpas

At the local level, the team of local government representative; Gup, Tshogpa, Mangmi will make recommendation for GRM

Appeal

In a situation where individuals who lodged category 3, 4, and 5 complaints feel dissatisfied with the resolution or action taken, channels for appeal/ escalation of the complaint to a higher level should be provided. Timelines and deadlines for responding to appeals will be dealt with on a case-by-case basis.

L. Sustainability

Institutional and financial sustainability of the project is considered in its scope and design. The project would rely on, and at the same time strengthen, the existing implementation arrangements of the RGOB, namely the delivery systems of essential health services and SBCC, use of existing payment and information/tracking systems, as well as the engagement of local government and community mechanisms. To facilitate financial sustainability, the cash component of the project would focus only on a select set of beneficiaries, the socially and economically vulnerable PLW. In addition, the use and strengthening of existing implementation arrangements would significantly reduce the overall cost of project, which is currently estimated at about US$650,000 per year, about 0.8% of annual health budget (about US$77 million in 2021). Moreover, there is strong political commitment and ownership from the Government of Bhutan to improve last-mile services delivery to increase inclusion and utilization of health services by PLW. This project is aligned with the Policy to Accelerate Mother and Child Health Outcome - 1000-Day Plus, which aims to increase investment in people to ensure that every child in Bhutan has the best start in life, protecting Golden 1,000 Days, and by the Maternal Child Health Program that was launched in October 2023.

M. Project Risks

The project outcomes depend on having accessible, functional, and staffed health facilities across the country. Given the current challenges faced by health system to provide services to population, key desired outcomes related to utilization of health services are at risk. To mitigate risks associated with this, government has recently announced an increase in salaries of health officials to reduce attrition rate, is continuously working on increase quality of supply side through international partners such as from the World Bank, JICA and ADB, and have allocate funds on MCHP supply side activities to improve quantity and quality of MNCHN services available. In additional, limited accessibility of payment points, mainly in remote areas, can also affect key project outcomes. To mitigate this risk, the Bank of Bhutan will offer to CCT beneficiaries' access to a network of authorized agents that provide basic banking services, including cash withdraw, through its nationwide service named BoBConnect that is offered where bank branches are located afar.

N. PMU key positions

Project Director

He/she is nominated by the MOH and has the following key responsibilities:

- Review and approve annual plans and budgets prepared by the PMU.
- Provide overall strategic direction to the project implementers.
- Ensure coordination of the PMU with other departments of the MOH.

Program Manager

He/she is recruited by MOH under the project, and with the following key responsibilities:

- Lead the project as manager of the PMU and overall operations of the project, in coordination with and assistance from other supporting departments of the MOH.
- Oversee and provide technical support to the team in planning of day-to-day operations including development/update of Operations Manuals/Guidelines, Annual Work Plan and

Budgets, Annual Procurement Plans, Monitoring and Evaluation Plan, and all other implementation arrangements
- Supervise PMU staff, in the performance of their respective duties.
- Supervise and coordinates the preparation of progress reports, annual reports, project completion report and other reports that may be required by the GoB and the World Bank.

Environment and Gender Focal Point or Expert

He/she is nominated by the MOH and has the following key responsibilities:
- Develop a comprehensive mechanism for implementing and compliance monitoring of the project E&S requirements.
- Review and revise all the E&S and project implementation documents and ensure timely delivery of outputs in consultation with the World Bank.
- Ensure through regular field visits, discussion with respective focal persons and independent field monitoring that E&S compliance is being done at each site; appropriate mitigation measures are being adopted and properly reported back.
- Maintain a Stakeholder Engagement Plan for the project. Coordinate stakeholder engagement and consultation activities for the project,
- Conduct and carry out consultation, focusing on E&S impacts, throughout the project activities with affected stakeholders in particular with women (being the major project beneficiaries), children, and vulnerable groups including poor and persons with disabilities.
- Develop a GRM manual for the implementation of the AMCHP, with scope and types of grievances to be addressed, user-friendly procedure for lodging grievances, grievance redress structure, and internal and external grievance review mechanisms.
- Monitor the implementation and performance of the GRM system, and propose changes to the GRM manual. Produces regular reports on GRM complaints and resolutions.
- Prepare and disseminate annual status and assessment reports on: the responsiveness of the AMCHP to the needs of vulnerable groups and additional social concerns; social mobilization, citizen engagement, public information sharing, and social accountability activities and initiatives including those targeting vulnerable groups.

CCT Focal Point or Expert

He/she is nominated by the MOH and has the following key responsibilities
- Prepare and support the development of annual cash transfer budgets (expected amounts needed for beneficiary's payments and service charges to BOB).
- Prepare/endorse beneficiary payment lists as per schedule.
- Monitor functioning of the complete Payment Cycle throughout the payment period.
- Monitor compliance of BOB with the signed MOU
- Liaise with BOB for improving beneficiary related services and resolving payment related issues. Ensure efficient handling of payment-related complaints.

SBCC and Maternal Health Care Focal Point or Expert

He/she is nominated by the MOH and has the following key responsibilities
- Ensure that the SBCC materials are produced, and implementers are trained in the use of these materials.
- Supervise the implementation of the SBCC sessions by the relevant MOH staff or service providers.
- Monitor and report on the systematic implementation of the SBCC sessions to CCT and non CCT beneficiaries.
- Coordinate the activities of the AMCH project with the rest of activities under the Comprehensive maternal and Child Health program

IT Focal Point or Expert

He/she is nominated by the MOH and has the following key responsibilities

- Participate in all aspects of the development lifecycle of Information Services, Technology and Data Communications for the AMCHP, from design to development to deployment and on-going enhancement, including hardware/software acquisition, software development partnerships, data management and strategic organization planning.
- Liaise with GovTech on behalf po the PMU for maintenance amd further development of the TIS.
- Provide analysis of and identify gaps in existing internal organizational processes, pertaining to IT and Data Communication, and related procedures and their efficiency.
- Prepare Annual IT budget, work-plans and performance reports for management.
- Ensure that relevant MOH staff at the central, district and PHC level is trained in the use of the TIS.

Financial Management Focal Point or Expert

He/she is nominated by the MOH and with the following key responsibilities:

- Design and develop/update the existing protocols and procedures for payments to vendors or partner firms, Conditional Cash Transfer (CCT), including payment reconciliation.
- Prepare and support the development of annual budgets, including CCT payment schedules.
- Analyze, plan, design, implement, and monitor and ensure compliance with internal control framework (Operations Manual, SOPs and the Bank's fiduciary guidelines etc.) and government rules and procedures while processing beneficiary and other payments.
- Ensure that No Objection Letter (NOL) is obtained from the Bank for every prior review activity before processing any payment.
- Prepare cash forecasts on quarterly basis, and submit to the World Bank for advance and replenishment of advance, once allowed.
- Prepare and process withdrawal application in accordance with the Bank's Disbursement Guidelines.
- Oversee recording of all transactions timely and accurately in the books of accounts and ensure that no expenditure remained unaccounted.
- Ensure maintenance of all data and record in soft and hard form for review by Bank Missions, third party monitoring agents, and external and internal auditors.

Procurement Focal Point or Expert

He/she is nominated by the MOH and has the following key responsibilities

- Lead the overall project procurement and contract management activities
- Develop, monitor, implement and update Annual Procurement Plans
- Lead the monitoring and recording of procurement activities under Systematic Tracking of Exchanges in Procurement (STEP), with technical and subject-specific assistance.
- Assist technical teams with development of generic and policy compliant ToRs and specifications, as relevant.
- Manage the complete procurement cycle, including Identifying the appropriate methodology for a given need of procurement, advertising processes for procurement, procurement correspondence, bids receipt, bids opening, contract negotiations, contract signings etc. in strict accordance with Bank's Procurement Regulations.
- Provide guidance to members of procurement committees and prepare evaluation reports of proposals/bids, and communications regarding contract awards.
- Lead contract negotiations with consultant, service providers, suppliers and contractors.

- Develop and implement a proper documentation and filing system which provides transparency; proper record control; security of documentation (particularly sealed bids) in compliance with national regulations and national laws and regulations

M&E Specialist

He/she is recruited by MOH under the project, and with the following key responsibilities:

- Assist in development of the M&E Manual, standard monitoring tools and approaches including M&E dashboards for PMU and MOH's management.
- Assist in the development of Log-frames, Annual Monitoring Plans and relevant data-collection systems, for tracking and monitoring of project activities Keep the aforementioned documents updated, in accordance with project activities and timeframes, as relevant.
- Develop baseline data for all relevant project indicators.
- Design and develop ToRs for procurement of consultancy services for surveys/baselines, assessments including Mid/End-Term evaluations, operations review (spot checks and process evaluation).
- Track progress of various project activities as per work plans to ensure timely achievement of milestones and deliverables.
- Undertake regular monitoring visits to project districts
- Produce reports on M&E findings and prepare presentations based on M&E data as required.
- Support the implementation of a knowledge management and learning strategy
- Keep record of the monitoring reports prepared by internal M&E and TPE.

Administrative Assistant

He/she is recruited by MOH under the project, and has the following key responsibilities:

- Responsible for day-to-day correspondence, information sharing, filing and ensuring appropriate follow up actions are taken on all correspondence.
- Schedule the organizational calendar and update as needed.
- Provide logistic and office support to PMU staff for executing their responsibilities.
- Keep filing system up to date and accessible.
- Prepare reports on expenses, office budgets, and other expenditures.
- Convene admin. meetings and take minutes of the meeting.
- Undertake travel and accommodation arrangements for office staff and managers, as and when required, overseeing and preparing expense reports and budgets.
- Organize and arrange seminars, workshops, launching ceremonies, meetings, and other events, as required by the staff.
- Monitor and maintain inventory of office equipment and supplies; order replacement supplies as needed.

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MINISTRY OF HEALTH

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ACRONYMS

ANC	Antenatal care
BOB	Bank of Bhutan
BP	Blood Pressure
CCT	Conditional Cash Transfer
DPHO	District Public Health Officer
DVT	Deep Vein Thrombosis
FHR	Fetal Heart Rate
ePIS	Electronic Patient Information System
GAO	Gewog Administrative Officer
GRM	Grievance Redress Mechanism
HIV	Human Immunodeficiency Virus
HW	Health Worker
IMR	Infant Mortality Rate
IYCF	Infant and Young Child Feeding
MNCH	Maternal, Neonatal and Child health
MOH	Ministry of Health
NKRA	National Key Result Areas
PHC	Primary Health Centre
PNC	Postnatal Care
SBCC	Social and Behavior Change Communication
TIS	Tracking Information System
TFR	Total Fertility Rates
TIS	Tracking Information System
U/S	Ultrasound
U5MR	Under Five Mortality Rate
VHW	Village Health Worker

I. INTRODUCTION

1.1. Background and Rationale for AMCH project

Bhutan has made significant progress improving human capital but still has a long way to go to realize its full potential. According to the Human Capital Index 2020, a child born today in Bhutan will be only 48 percent (and with the COVID-19 pandemic this index may have further declined in recent years) as productive in adulthood as they could have been with a complete education and better health care. Before the COVID-19 pandemic, the observed human capital gains in the form of reduced stunting and child mortality and improved educational outcomes reflected the RGOB's investments to expand the coverage and improve the quality of health and education services.

The benefits of these gains, despite large and free education and health system, however, have not been equally distributed both in terms of geography and across income quintiles. Access to maternal and child health and nutrition services, early childhood care and development (ECCD), quality education, and skills training that would improve the transition from birth to school to work, are worse in remote and rural locations, and among poorer households. On maternal, neonatal and child health (MNCH), Dorji et al (2019) shows that antenatal care and institutional birth delivery are much lower in the rural and remote areas of the country, and among women with lower levels of education and lower socioeconomic status.

Furthermore, the COVID-19 pandemic disrupted provision and utilization of essential services, such as antenatal care which dropped from 82 to 76 percent for four visits and from 54 to 25 percent for eight visits. According to the past five Annual Health Bulletins (AHB), 2018-2022, the percentage of women that had first antenatal care visit during the first trimester of pregnancy increased from 44.8 percent to 48 percent, then to 54 percent; but since COVID-19 pandemic, it has decreased to 53.3 percent and bounced back to 54.7 percent. Similar pattern was observed for postnatal care: completing 2 or move visits increased from 79 to 85.8 and then to 88.6 percent, but post COVID-19, it has decreased to 76.5 percent, and bounced back to 80.7 percent. Finally, maternal mortality ratio increased from 86 to 89 per 100,000.

Consequently, providing comprehensive and quality maternal and child healthcare in the country is a national priority. In the 12th Five Year Plan[1] (2018-2023), targets for maternal and child health constitute some of the most important components of the National Key Result Areas (NKR-A). Furthermore, Bhutan is also committed to the global Sustainable

[1] Twelfth Five Year Plan, Gross National Happiness Commission (2019). https://www.gnhc.gov.bt/en/wp-content/uploads/2019/05/TWELVE-FIVE-YEAR-WEB-VERSION.pdf.

Development Goals (SDGs) which include specific targets for maternal, neonatal and child health (MNCH).

In order to accelerate improvements in MNCH outcomes, improved utilization of health services has been identified as a key strategy. Demand-side programming, which includes, *inter alia*, the provision of incentives, has been successful in many settings.

Under Bhutan's Accelerating Maternal and Child Health Project (AMCHP), similar demand-side programming is proposed, in an effort to improve utilization of target maternal and child health services. Specifically, a conditional cash transfer (CCT) program will provide certain monetary incentives to selected pregnant and lactating women with children under 2 years old (PLW) in Bhutan who avail the requisite MNCH services. The overarching aim, in so doing, is to accelerate improvements in MNCH outcomes.

1.2. Policy Context

The Constitution of the Kingdom of Bhutan mandates the state to provide free basic health care to all Bhutanese, with preventive and primary health care services playing a major role in the Bhutanese health system. The National Health Policy (2011)[2], policy on accelerating mother and child health outcomes and the Food and Nutrition Security Policy of the Kingdom of Bhutan (2014)[3] promote quality maternal and child health and nutrition through the provision of comprehensive quality health services and cross-sectoral strategies.

Consistent with these strategies, the Ministry of Health (MOH) has developed the National Reproductive Health Strategy (2018-2023)[4], Child health strategy and the Bhutan Every Newborn Action Plan (2016-2023)[5], which aspires to accelerate reductions in the maternal and child morbidity and mortality. The AMCHP is consistent with these national policies and strategies.

[2] National Health Policy (2011). http://apps.who.int/medicinedocs/documents/s19416en/s19416en.pdf.

[3] Food and Nutrition Security Policy of the Kingdom of Bhutan (2014). https://www.gnhc.gov.bt/en/wp-content/uploads/2017/05/FNS_Policy_Bhutan_Changed.pdf.

[4] Bhutan National Reproductive Health Strategy (2018-2023). https://www.health.gov.bt.

[5] Bhutan Every Newborn Action Plan (2016-2023). https://www.unicef.org/bhutan/media/206/file/Bhutan%20Every%20Newborn%20Action%20Plan.pdf.

1.3. The AMCH Project

The proposed project will address PLW's inequalities of opportunities and the financial burden among socially economically and vulnerable PLW, which are linked to out-of-pocket costs that are significant barriers to accessing health care, such as costs associated with transportation (e.g., three times higher in rural areas as compared to urban) or to loss of daily wages/workdays. As women face competing household priorities (household chores and farm work take precedence over seeking health care), negative social and cultural norms, family pressure and health illiteracy, the proposed project will promote social mobilization, social and behavior change communications (SBCC) activities to all PLW across the country to increase their awareness and knowledge about parenting, childcare, nutrition and early stimulation. In addition, eligible ones (i.e., socially, and economically vulnerable) will receive conditional cash transfers (CCTs) linked to utilization of MNCHN services. The two activities are designed to increase the Golden 1,000 Days outcomes in Bhutan by addressing existent demand side barriers for utilizing and benefiting from existing supply of MNCHN services available nationwide.

The innovative aspects of the proposed project build on promoting strong collaboration between Social Protection and Jobs and Health sectors guided by the international experience to help Bhutanese families make better human capital investments. Moreover, benefiting from the current banking landscape and IT accessibility/connectivity of Bhutan, the project will promote the use of disruptive technologies to facilitate electronic transactions through banks and to have better communications between community leaders, health workers and beneficiaries, and the project can serve as an initial platform for broader provision of services to socially economically and vulnerable ones in the country in order to improve human capital and reduce vulnerabilities, including against shocks.

The proposed project benefits from the projects supported by the Japan International Cooperation Agency, such as one which is piloting the use of technology to remotely monitor fetal heart rate and uterine contraction of pregnant women and will help detect high-risk pregnancies for timely referral and care.

The proposed project development objective is then to enhance utilization of maternal, neonatal, child health and nutrition services (MNCHN) by pregnant and lactating women in all districts of Bhutan.

1.4. Objective and use of this manual

The objective of this manual is to provide detailed guidelines to implementers of the AMCHP, at central and decentralized levels.

This document is a living document that can be revised from time to time by the GoB to address emerging developments in the country, but in consultation with the World Bank.

This manual aims to help key stakeholders as district health officers, local governments, health officials and health service providers on how the CCT will be implemented.

The manual is organized in several sections:

- Section I provides a general introduction on the AMCHP.
- Section II summarizes the key design features, policies and parameters of the project.
- Section III discusses the main outreach and communication activities that will support the implementation of the project.
- Section IV, V and VI detail the main processes across the project cycle: registration and enrolment, conditionalities and compliance verification, and payment.
- Section VII explains how the Grievance Redress Mechanism will be implemented.
- Section VIII describes the Monitoring and Evaluation of the project.
- Section IX lists the key stakeholders and describes their roles and responsibilities in the implementation of the project.

The manual also has one annex: the results Framework, and a Financial Management and a Procurement annex.

II. PROJECT POLICIES AND PARAMETERS

2.1. Target Beneficiaries

A PLW is eligible for registration in the AMCHP provided that:

- She has been confirmed pregnant following a first booking at a Health Facility in Bhutan; or
- She is the mother of a child under 2 years of age, at the time of registration in the project.

2.2. Confidentiality of Information Regarding Pregnancy

Women may prefer to keep their pregnancy confidential for a number of weeks or months. The project, therefore, must guarantee this confidentiality, to the extent possible. This implies that:

- Data collected at the time of first booking and enrollment should only be accessible by key individuals responsible for project implementation, such as the health staff, and by those identified by the PLW.
- PLW should explicitly give their prior consent for Health staff and other local authorities to pay home visits for stimulation and for follow up activities in case of non-compliance to Conditional Cash Transfer (CCT) conditionalities. Prior consent should be given during the registration (and be specifically recorded in the TIS).
- Health staff at the time of registration should communicate to pregnant women that their data will be treated confidentially.

2.3. Social mobilization and Social and Behavior change communications (SBCC)

SBCC is offered to all PLWs and other family members (including the fathers) whenever is possible on a regular basis.

SBCC is to be carried at the national level thought massive information campaign, and at both health facility and community level (for example through Outreach clinics) to all PLWs by health officials and Village Health Workers (VHW).

The HWs and other stakeholders in charge of delivering SBCC must be trained and equipped with materials and tools by MOH.

2.4. Eligibility criteria for the CCT

The CCT is only offered to the PLWs who are considered the most socially and economically vulnerable. PLWs are eligible for enrolment in the AMCHP provided they meet a combination of categorical criteria and welfare base criteria.

Categorical criteria are straightforward, as follows:

- Be a registered PLW in the TIS: either as a pregnant woman or with a child under 24 months of age, at the time of enrollment.
- Be willing to participate in the program.

Welfare based criteria

- The welfare base criteria to identify the socially and economically vulnerable are determined through a proxy means test (PMT) that uses a "predicted" household per capita welfare for each PLW compared to a poverty line to determine eligibility.
- The parameters (variables and weights) of the PMT are determined using the 2022 Bhutan Living Standard Survey that collects information on household welfare and the characteristics correlated with it and statistical modelling.
- The precision of the PMT and parameters (variables and weights) are "confidential" and MOH can make it available for audit purposes of the AMCHP as needed through official requests.
- The *Poverty Line is* set for the poorest 20% of the PLWs (equivalent to an income of Nu. 7,373 per household per month). Those PLWs with a PMT score *below or equal* to Poverty line set are deemed eligible for CCT.

2.5. Level, Frequency and Duration of CCT Benefits

Value of cash transfer

CCT Eligible PLWs receive BTN 1,500 per month as CTT, through electronic transfers directly to their individual bank accounts. The transfer amount represents around 50% of food poverty line and 25% of poverty line according to the BLSS 2022.

Frequency of cash transfers

All CCT beneficiaries have the CTT amount transferred to their bank account every month, at the end of the month.

There will be a cut-off date for new enrolments (for example, the 20th of the month), after whoch newly enrolled PLWs will get their first payment not at the end of the same month but at the end of the followimg month. *Example: if a PLW is enrolled before March 20, she will get her first payment at the end of March. If she is enrolled between March 20 and April 20, she will get her first payment by at the end of April.The cut-off date will be determined when the*

payment starts at the beginning of the project, and will depend on the time needed to produce the payroll and procee payments, but also on the time needed to create a bank account in case the PLW doesnñt have a bank account yet.

The last transfer must occur during the last payment cycle before the child reaches the age of 24 months.

Maximum number of cash transfers

The maximum number of CTT is fixed at 33 (paid monthly) which corresponds to the maximum period of 9 months of pregnancy and 24 months until the child is two years old. However, since pregnancies are likely to be detected and confirmed at the first booking during the third month, it is expected that CTT number will not exceed 31 in most cases (7 months of recorded pregnancy and 24 months delivery).

However, this could be lower for some beneficiaries depending on the following:

- Date of first booking and enrollment, and therefore date of first transfer.
- Date of delivery (if delivery occurs before the 9th month, this may shorten the total number of months of participation in the program).
- Any temporary suspension for non-compliance with project conditionalities.

2.6. Estimated Monthly Caseload and Number of CCT Beneficiaries

The monthly case load of CCT beneficiaries is approximately 4.000, i.e. the project makes 4.000 payments every month.

At the end of the project, the cumulative number of CCT beneficiaries will be around 10.000.

2.7. Recipient of the CCT Payments

The recipient of the CCT is the enrolled PLW. The benefits are therefore transferred to a bank account which must be in her name, unless she is less than 18 years old at the time of enrollment, in which case a tutor (her mother or any other close relative of her choice) must be appointed as per BOB rules.

In case of death of the PLW during or after delivery, the program will designate a new recipient. The new recipient is the next of kin who will be the caregiver of the child. The decision of who should be the recipient of the benefits will be taken after submission of proof of death of the mother (e.g., death certificate) to the PMU where further validation may be carried out as deemed necessary.

2.8. Conditionalities for CCT beneficiaries and Compliance Verification

In the case of the CCT beneficiaries, all the visits captured in the mother and child handbook are compulsory and represent conditionalities that may affect their CCT payments. CCT payments may been suspended in case of missing three consecutive visits. The list of conditionalities, the compliance verification process and how this may affect the CCT payments is described in Section V of this manual.

When a CCT beneficiary complies with the calendar of planned visits, she continues to receive her payments without interruption. If she misses a planned visit, alerts are generated by the TIS, which may eventually lead to her suspension from the payroll if she misses two consecutive visits.

The details of compliance verification and how they affect the CCT payments is described in detail in section V.

2.9. Special Cases

Cumulating cash transfer of two pregnancies

If a beneficiary mother becomes pregnant again before the end date of her current benefits cycle (i.e., before the 24-month anniversary of her last child), she is entitled to cumulate the CCT benefits of her new pregnancy with the previous pregnancy (up to the end of the benefits period of the previous pregnancy).

For example, if a beneficiary mother becomes pregnant (pregnancy 2) when her previous child is 12-month-old (pregnancy 1), she is entitled to enroll in the program for pregnancy 2 and cumulate the cash monthly benefits of both pregnancies for the following 12 months. After that date she will only receive the benefits attached to her second pregnancy.

Cumulating benefits is limited to two children, or two consecutive pregnancies.

Cumulating cash transfer in case of multiple fetus in the uterus

In case of multiple fetus in the uterus, benefits until delivery remain the same as for one child. After delivery, benefits are multiplied by the number of born children. *Example: a woman expecting twins will be transferred twice the monthly benefits after the children birth.*

First booking, or subsequent visits, realized abroad

If the first ANC and/or PNC visit takes place abroad, the PLW must register in a health facility in Bhutan and can still become a CCT beneficiary at any stage during her pregnancy, or once

the child is born. If eligible for CCT, she automatically enters in the payroll for the regular transfers as per project rules.

Delivery realized abroad

If a mother comes back home after delivering abroad, she is still eligible for registration and enrollment in the project.

Death of the mother

If a beneficiary mother dies during or after delivery, and her child survives, CCT will continue to be paid to the new recipient (usually the caregiver of the child).

Miscarriage or early pregnancy failure

In case of miscarriage or early pregnancy failure, the beneficiary automatically exits the project and CCT are discontinued after two additional payments.

Stillbirth, neonatal death or death of child

In case of stillbirth, neonatal death or death of the child, the CCT beneficiary automatically exits the project and CT are discontinued after two additional payments.

III. TRAINING, COMMUNICATION AND OUTREACH

3.1. Training of Health Professionals

The implementation of the AMCHP requires initial as well as regular training of health professionals on proper delivery of MNCH visits. These trainings reinforce the ability of health professionals to deliver the right messages during visits, and, in particular, to communicate the importance of all visits to pregnant women, mothers and family members. Notwithstanding this, it is important to ensure that health workers have the appropriate equipment, commodities and supplies, to translate their knowledge into quality delivery of the key MNCH services that are of particular interest under the AMCHP.

3.2. Training on Project / CCT program

The Ministry, through the Department of Public Health (DoPH), provides technical oversight and guidance, and houses the Project Management Unit (PMU), which assumes day-to-day management, track beneficiaries, and provides reporting on progress. The DoPH relies on the District Health Officers (DHO) to oversee the registration of beneficiaries in their districts and oversee CCT payments and progress monitoring. DHOs must be trained on project operations and must further train the Health Assistants. Health Assistants must also be trained in the different modules of the TIS.

The local government (LG) also plays an important role in the project implementation from the district (dzongkhag) to village (Chiwog) level. DHOs must sensitize LG officials on the objectives and key processes of the project and on selected activities for which they have specific responsibilities (such as the GRM).

3.3. Outreach and Communication

A general communications campaign must be launched at the beginning of the project, and in a regular way once the project is up-and-running.

The MOH must develop specific communication material directed at pregnant women who wish to enroll in the program. In particular, communication material (such as a leaflet, for example) must be made available to women willing to register. In addition, information sessions in outreach clinics by health workers must take place to explain the benefits of the project.

The communications campaign should focus on:

- Objective of the project.
- Benefits offered by the project.
- Enrollment process (including eligibility criteria) .
- CCT Conditionalities.
- Compliance verification and cases of suspension of CCT payments.
- Exit from the project.

IV. REGISTRATION AND ENROLMENT

4.1. Overview

The first booking is the first voluntary visit that a woman, who thinks that she is pregnant, makes to an MCH clinic or a PHC to confirm her pregnancy. Once the pregnancy is confirmed, the HA must register the pregnant woman in the AMCHP, using the TIS.

The registration gives the pregnant woman access to SBCC activities, and access to SMS messaging and reminders (once these functionalities of the TIS will be available),

The registration may also lead to the enrollment of the PLW as a CCT beneficiary, depending on her PMT score automatically calculated by the TIS.

4.2. Communication to be made to PLW prior to registration and enrollment

At the start of the registration, the HW must inform the woman about the AMCHP, its benefits and conditions, and how the registration and enrollment are made. The HW must, in particular, clearly explains the following points:

- The registration into the project is voluntary, and confidential.
- Getting registered may give the opportunity to get enrolled and to receive financial support
- Not all PLW receive financial support: only the most socially and economically vulnerable PLW are eligible to the CCT.
- The decision on whether a PLW receives financial support is not made by the HA: it is calculated automatically by the system.
- If PLW does not agree with the eligibility decision, she can lodge a complaint through the GAO within 30 days of registration (see section on GRM).

4.3. Registration

The first step in the registration process is for the HA to complete the registration form in the TIS. This form contains the basic data of the PLW (name, date of birth, etc). At the start of the project in early 2025, this data still need to be entered in the TIS manually by the HA (at a later stage, it is expected that the TIS will extract this data automatically from the ePIS).

4.4. Calculating the CCT Eligibility Score

Once the basic data of the PLW is collected and entered in the TIS, the HA proceeds to collect the data that allow the calculation of the eligibility score, which determines whether the PLW

is eligible for the CCT. The HA will is prompted by the TIS to ask a number of questions to the PLW, and report the answers in the TIS.

Once all the data is entered, the eligibility score is automatically calculated by the TIS. The HA immediately informs the PLW whether she is entitled to the CCT payments.

4.5. Appealing the Eligibility Decision

A PLW may appeal the eligibility decision (once the GRM system and correspondent TIS module have been designed, which may occur only a few months after the start of the project).

4.6. Enrolment as a CCT Beneficiary

In case the PLW is eligible for the CCT, the HA must proceed to her enrolment in the program.

Before proceeding to the enrollment of the PLW as CCT Beneficiary, the HA must communicate to the PLW:

- The level of benefits she will receive, ie. BTN 1.500 per month
- The duration of these benefits, ie. Until her child reaches the age of 24 months
- The importance of complying with all visits annotated in her MCH handbook, and the rules concerning suspension of payments.

In order to complete the enrolment process, the PLW must provide a Bank account number, to be entered in the TIS by the HA:

- If the PLW already has a Bank account number, this number is recorded immediately in the TIS by the HW.
- If the PLW does not have a Bank account number: the HA needs to collect additional data from the PLW, and the TIS creates an application to open an account at the BoB. The BoB, through an agreement with the MoH (described in a MoU) receives the application automatically with the relevant PLW data. The PLW signs and validates the creation of her account when she goes to the BoB to cash out her first payment.

4.7. Initial Rollout of the Project

At the start of the project, in 2025, all currently pregnant women (regardless of the stage of their pregnancy), and all mothers with a child younger than 24 months must have the opportunity to register in the AMCHP. The registration must be done by a HA at any health center, during the first visit after the date of the launching of the registration campaign.

V. CONDITIONALITIES AND COMPLIANCE VERIFICATION

5.1. Overview

All PLWs registered in the TIS must comply with a number of ANC and PNC visits and ensure full immunization of their child.

For CCT beneficiaries, these visits are mandatory in order to receive their monthly payments and are therefore considered as "conditionalities". In general, the objective of the project is to support PLW to overcome the multiple barriers that they may encounter to fulfill these conditionalities: the project is therefore not punitive in essence, and always tries to bring back PLWs who may have interrupted their scheduled visits. However, if a CCT beneficiary misses three consecutive visits in the calendar she has been issued, her payments may be suspended under certain conditions further described below in this section.

5.2. List of Conditionalities

The conditionalities are listed in the table below.

Table 1. List of conditionalities

Visit	Time frame for the visits	Overview of services
1	Before 12 weeks after conception	Establish early dating by ultrasound (where possible). Laboratory tests, including urine and blood. Help mother with hyperemesis in early pregnancy, diagnose chronic hypertension and twins. Provide health education on healthy eating and staying physically active. Complete birth preparedness plan. Rule out any dental problems (dental caries, gingivitis, calculus) and conduct maternal mental health screening Provide Fe/FA/MMS tablets. Start calcium Lactate at 12 weeks.
2	20 weeks	Dating by ultrasound (if not already done). Listen for fetal heart rate (FHR) once uterus is palpable. Diagnose twins or PIH. *Look for any signs of violence or abuse. Provide health education & Fe/FA/MMS/deworming medicine
3	26 weeks	Screen for diabetes. Monitor fetal growth, plot fundal height and screen for PIH, and check Hemoglobin. Look for any signs of violence or abuse.
4	30 weeks	Monitor fetal growth, plot fundal height, and screen for PIH, check Hemoglobin. Do fetal monitoring. Counsel about breast feeding. Look for any sigh of violence or abuse
5	34 weeks	Monitor fetal growth, plot fundal height, and screen for PIH, check Hemoglobin. Counsel about breast feeding. Look for any sigh of violence or abuse
6	36 weeks	Monitor fetal growth & plot fundal height, presentation, lie, & mal-presentation, and FHR. Check Hemoglobin & repeat TPHA/RPR, HBs Ag, & HIV. US to check fetal weight, AFI, and presentation. Discuss birth preparedness. Look for any signs of violence or abuse and conduct maternal mental health screening

Visit	Time frame for the visits	Overview of services
7	38 weeks	Monitor fetal growth & plot fundal height, presentation, lie, and refer if needed. All previous caesarean patients should be referred to OB/GYN. Counsel about exclusive breast feeding for first 6 months. Look for any signs of violence or abuse
8	40 weeks	Monitor fetal growth & plot fundal height. (AFI, and presentation, if US available.) If any problem, admit or refer. If patient stays nearby the health facility and has no problems, she may be allowed to wait until 41 weeks, after which time she must be admitted or referred for delivery
9	41 weeks	Delivered in the health facility OR attended by a trained health worker. Early Essential Newborn Care. Delivery assessment as per midwifery standard.
		For Child: Birth dose for vaccination, check Wt., Lt., Ht. and HC, initiate BF, show affection, love and talk to baby, inform about safety measures
10	3 days after delivery	***For Mother:*** Check Temperature, BP and Pulse. Assess for: Bleeding, Fever, and Mood/Behavior changes. Examine: Perineum for Episiotomy/Tear/Haematoma, HoF, Breasts, Legs for signs of DVT, and CS scar for signs of infections, and any other issues Assist and encourage mother with breast feeding. Ensure adequate food and fluid intake and support for the mother. Provide a supply of iron/folate tablets/single dose of vitamin A (200,000 IU) once after delivery. Discuss danger signs with the mother during postpartum period
		For Child: Check Temp, Weight, and Physical exam (including breathing, skin color, umbilical cord, etc.). Ask about stooling, urination, and evaluate breast feeding. Observe umbilical cord. If dry remove the clamp.
11	1-2 weeks after delivery	***For Mother:*** Check Temperature, BP, Pulse, and Hb. Inquire about: Bleeding, Fever, and Mood/Behavior changes Examine: Perineum, Episiotomy/Tear, HoF, Breasts, Legs for signs of DVT, and CS scar for signs of infections, and any other issues. (Fundus should not be palpable after 10-12 days). Encourage exclusive breast feeding for the first 6 months. Assess for good positioning and attachment. Provide a supply of iron/folate tablets, and a single dose of vitamin A (200,000 IU) if not previously done.
		For Child: Examine as above. Focus on signs of infection (skin pustules, eye discharge, jaundice, etc.). Enquire about stooling, urination, and evaluate and counsel mother regarding exclusive breast feeding. Monitor weight. Newborns should have regained their birth weight by 2 weeks of age.
12	3 weeks after delivery	***For Mother:*** Check Temperature, BP, Pulse, and Hb. Inquire about: Bleeding, Fever, and Mood/Behavior changes Examine: Perineum, Episiotomy/Tear, HoF, Breasts, Legs for signs of DVT, and CS scar for signs of infections, and any other issues. (Fundus should not be palpable after 10-12 days) Encourage exclusive breast feeding for the first 6 months. Assess for good positioning and attachment. Provide a supply of iron/folate tablets, and single dose of vitamin A (200,000 IU) if not previously done
		For Child: Provide thorough exam including all of the items above. Continue to encourage exclusive breast feeding for the first 6 months. Check weight, length, and HC and record and plot them. Ask mother about stool color.
13	6 weeks after delivery	***For Mother:*** Examine for any problems. Check mother's Hb. Advise on pap smear and provide family planning counseling and services

Visit	Time frame for the visits	Overview of services
		For Child: Check Weight and Physical exam Provide immunizations per guidelines. Stress the importance of monthly visits to monitor the baby's growth and to get all required immunizations as per MCH schedule(OPV/DTP-HEP B/PCV). Check weight, length, and HC and record and plot them
14	10 weeks (2 and 1/2 months)	OPV, DTP-Hep B-Hib, PCV, check Wt., Lt., Ht. and HC, Exclusive breastfeeding, BCDST, inform about safety measures
15	14 weeks (3 and 1/2months)	OPV, IPV, DTP-Hep B-Hib, Rota, check Wt., Lt., Ht. and HC, Exclusive breastfeeding, BCDST, inform about safety measures
16	18 weeks (4 and 1/2 months)	Check Wt., Lt., Ht. and HC, Exclusive breastfeeding, BCDST, inform about safety measures
17	6 months	Check Wt., Lt., Ht. and HC, Give Vit A, BF and complementary feeding , BCDST, advise on dental care, inform about safety measures
18	8 Months	IPV, check Wt., Lt., Ht. and HC, BF and complementary Feeding/Sprinkles, BCDST, advise on dental care and safety measures
19	9 Months	OPV/PCV/MMR. Check Wt., Lt., Ht. and HC, BF and Complementary Feeding, Child Development Screening, Dental Care and Safety measures.
20	10 Months	Check Wt., Lt., Ht. and HC, BF and Complementary Feeding/sprinkles, BCDST, dental care and safety measures
21	12 Months (1 Yr)	Check Wt., Lt., Ht. and HC, BF and Complementary Feeding, Child Development Screening, Dental Care, Inform about Safety measures. Give Vitamin A
22	1 year 3 months	Check Wt., Lt., Ht., HC, deworming, continue to expand complementary feeding/sprinkles, continuing breast feeding, dental care, inform about safety measures
23	1 year 6 months	Check Wt., Lt., Ht., HC, Vit A, continue to expand complementary feeds/sprinkles, continuing breast-feeding, BCDST, dental care, inform about safety measures
24	1 year 9 months	Check Wt., Lt., Ht., HC, deworming, continue to expand complementary feeds/sprinkles, continuing breast feeding, BCDST, dental care, inform about safety measures
25	2 years	MMR, DTP, Check Wt., Lt., Ht., HC, Vit A, continue to expand complementary feeds, continuing breast feeding, BCDST

5.3. Compliance Verification

Reminders before each visit

SMS reminders are sent automatically to the PLWs three working days before each appointment (this functionality of the TIS may not be in place at the beginning of the project). A PLW has the opportunity, for exceptional and valid reasons, to contact the HA at her usual health facility and ask for a modification of the date of the visit. In case this change of date is reasonable, the HA may modify the date manually in the TIS and communicates the new date to the PLW.

Updating the TIS at each visit

At each visit realized by a PLW, the HW must record the visit as completed in the TIS. This must be done on the same day as the visit takes place, so as not to create a delay that may have a consequence on the payment of the PLW.

When a visit is scheduled or takes place outside the health facility that the PLW usually visits (for example when an ultrasound is made at a hospital which is not the usual health facility), the HW may not be able to record the visit the same day. It is the responsibility of the PLW to contact her health facility and signal that she has made the visit and bring the proof of the visit so the HW can record the visit in the TIS as completed.

Alerts when a visit is missed

If the PLW misses a visit, she gets an SMS (generated through the TIS, although this functionality may not be immediately available at the beginning of the project)) communicating to her:

- That she has missed her scheduled visit.
- That she must contact her health facility immediately to reschedule the visit as soon as possible.
- If this is due to the fact that the HA has not yet recorded her visit, but the visit has actually taken place, she must remind the HA to do so.

5.4. Suspension of CCT Payments

If the PLW still does not comply with the conditionality or does not contact the HA to agree on a rescheduling of the visit within a reasonable time, the visit is considered as “missed” in the TIS within 2 days after the initial date.

If the PLW finally complies with the visit or complies with the next visit in the calendar, then her payment is not suspended. If she misses three consecutive visits, then her payment will get suspended from the date of the last missed visit.

Suspended CCT payments may resume at any time when the CCT beneficiary resumes compliance with the calendar of visits.

When an ANC or PNC visit is missed, and depending on the date of the next visit, it may be replaced by the next visit. In some cases, not all ANC visits may be possible: for example, the last visits before delivery may become irrelevant if the beneficiary delivers before the due delivery date. Hence, it is not expected that all beneficiaries complete the same number of visits.

Immunization visits, however, follow a specific schedule and specific reminders will be sent to the PLW (through the TIS when this functionality is ready) to ensure timely immunization visits. All immunization visits are compulsory, with a certain number of days or weeks between immunizations. Compliance with immunization visits, therefore, functions in a somewhat stricter way than ANC and PNC visits.

5.5. Cancellation of CCT Payments

The CCT payments of a PLW may be cancelled in the following cases:

- Automatically after payment of the last transfer (when the child reaches the age of two years, i.e., 24 months after delivery).
- If The CCT beneficiary indicates that she is moving abroad and will not come back before her child reaches 24 months of age.
- If the CCT beneficiary voluntarily chooses to withdraw from the project.
- In case of miscarriage or death of the child (see section on special cases in section 2).

VI. PAYMENT SYSTEM

6.1. Beneficiary Bank Accounts

Payment of benefits are made through the banking system. As previously noted, all CCT beneficiaries must have a Bank account to enroll in the program. Beneficiaries can use their own existing bank account or can open a new Bank account at BOB.

The HA must support the process of opening a bank account during enrolment. In order to apply for the opening of a bank account at BOB, the HA collects additional data through the TIS: this information is then automatically passed onto the BOB for further processing. The PLW just needs to sign on the opening of her bank account the first time she cashes out her CCT payments.

If the beneficiary is younger than 18 years, she cannot open a Bank account (as per banking regulations). She can however open a “Young Savers” account at BOB, and needs to nominate an adult to manage her account until she reaches the age of 18 (usually her mother or a close relative).

6.2. Date and Frequency of Payments

Payments are made regularly every month from the date the enrollment is effective. As outlined above, beneficiary data collected includes a bank account number, which is entered in the TIS at the time of beneficiary enrolment.

6.3. Disbursement Mechanisms

The MOH submits annual budget requirements for the AMCHP to the MoF. The budget release depends on the estimated amount of funds required for payment in the next year. This requires the MOH to be able to forecast an estimated number of potential project beneficiaries (and their payment tranches) on an annual basis. Based on the budget proposal, the MoF allocates an annual budget for the project to the MOH. Funds are deposited in the MOH’s letter of credit (LC) account in partner bank.

Based on the number of beneficiaries, the MOH needs to share with BOB, the payment amount and the list of beneficiaries with their details in order to process the transfer of funds to individual Bank accounts. Beneficiary details include the name, CID number, bank account number and the bank in which account is held.

VII. GRIEVANCE REDRESS MECHANISM

The AMCH project has a Grievance Redress Mechanism (GRM) which allows beneficiaries to lodge a complaint and/or seek clarification on project rules.

7.1. Principles

The principles guiding the GRM include:

- *Transparency*: beneficiaries must be able to access information relating to the processing of their complaint.
- *Confidentiality*: the name of the complainant, the alleged person that the claim may be referring to (where applicable) and the subject-matter of the complaint must not be made public.
- *Impartiality*: Decisions must be taken after due consideration of objective parameters.
- *Non-retaliation*: Complainants must be assured that lodging and submitting complaints will not adversely affect them.

7.2. Points of Entry

Complaints may be made at several entry points:

- Through the Local government functionaries.
- Through the Health Worker at the health facility where the PLW is registered.
- Through the DHO.
- Through the PMU in some exceptional cases.

Complaints and feedback may be made by project beneficiaries, members of the communities of intervention, health facility staff as well as and Local Government functionaries.

If a beneficiary or another stakeholder wishes to clarify certain aspects of the program, he/she may do that through a LG functionary or through a HA, and in that case the request for clarification does not need to be formally lodged in the TIS.

All other complaints may be formally lodged in the TIS by a HA. A confirmation number is sent by SMS to the complainer´s mobile number with a reference number (when this functionality is available in the TIS). In general, complaints must be resolved within 10 working days. More complex complaints (category 5 in the table below), must be resolved within 20 working days.

7.3. Categorization, Processing, Resolutions of Complaints & Feedback

The following table summarizes the main categories of complaints.

Table 2. List and categorization of complaints

Category	Lodged where and by whom	Resolution
Category 1: Request for information about the AMCH	Request of information made at Health Center by HW, or at community level through a LG functionary. No formal lodging of request in the TIS	All category 1 requests for information are addressed immediately by the LG and HW.
Category 2: Missed recording, loss of data	By HW. No formal lodging of request in the TIS.	Category 2 is resolved by HW
Category 3: Minor complaints, for example, Health professionals not available on planned date of visit, visit seemingly not entered in the system and beneficiary not receiving confirmation of visit by SMS.	Through HW or a LG functionary. Complaint is formally lodged in the TIS.	Category 3 complaints solved after contacting Health professional responsible for service provision, and/ or responsible for entering compliance data in the system.
Category 4: Complaints related to payments: transfers not available on Bank account at due date, and any issue regarding banking operations (e.g. no cash available at ATM)	Complaints can be made through a LG functionary or a HW and need to be formally lodged in the TIS.	Category 4 complaints are investigated by DHOs, who is responsible for contacting Banks. These complaints must be solved within 10 working days and the resolution swiftly communicated and explained to beneficiary.
Category 5: Appealing against the PMT score and request to become a CCT beneficiary.	Appeals can be made through a LG functionary or a HW within 30 days of registration. In case an exceptional request is made because of a serious change in socio-economic condition during pregnancy or after the child is born, a request for inclusion in the CCT can be made at any time. Appeals and special requests for inclusion must be lodged formally in the TIS.	Category 5 appeals are verified by the DHOs and final decision is made by the PMU.
Category 6: Complaints regarding fraud of any sort, such as forceful collection of funds or solicitation of tips, by Bank employees, by community members or Health professionals, etc.	These complaints may be lodged through a LG functionary, a HW, the DPHO, or the PMU.	Category 6 complaints like alleged staff misconduct require a thorough investigation, either by a DHO or the PMU. Must be resolved within 20 working days.

7.4. Appealing the Resolution of a Complaint

In a situation where individuals who lodged category 3, 4, and 5 complaints feel dissatisfied with the resolution or action taken, channels for appeal and escalation of the complaint to a higher level must be provided. Timelines and deadlines for responding to appeals are dealt with on a case-by-case basis.

VIII. MONITORING AND EVALUATION

This section provides information on the monitoring and evaluation activities of the project. The AMCHP Results framework is provided in Annex 1. The PMU, under DoPH, has the overall responsibility for project monitoring and evaluation, and, in effect, the four activities outlined below. Based on this section of the manual, the DoPH must develop a M&E strategy and plan.

8.1. Monitoring Indicators

The PMU must collect data regularly to inform both project implementation and outcomes indicators. The list of indicators, their baseline and their target values are presented in annex 1 of this manual ("Results Framework").

8.2. Spot-checks

Spot-checks are to be conducted with the objective of providing regular and timely feedback to the RGoB and stakeholders of the AMCHP on the extent to which project implementation is complying with the agreed project procedures. Access to this information enables the project management team to develop mitigating actions, target capacity building support and make any necessary adjustments to project design and implementation.

Spot-checks may be carried out by DoPH staff or external consultants. A sample of districts and gewogs, where the spot-checks are to be implemented, must be randomly selected. As the project matures, however, the gewogs selected could be those in which the numbers of complaints are higher than the average.

The spot checks use a mixed methodology approach combining document review, key informant interviews and beneficiary interviews to assess the extent to which procedures as outlined in this manual were followed. At each step, efforts must be made to triangulate information from different sources.

8.3. Process Evaluations

Process evaluations must be conducted by external consultants in selected districts and gewogs on an annual basis. The assessments must: i) describe the project implementation processes as implemented in reality and in the field and compare these with the processes described in the manual; ii) identify institutional roles and responsibilities at each step; iii) evaluate strengths and weaknesses in the implementation of the project; and iv) provide recommendations for improving project implementation.

8.4. Annual Audits

Annual independent technical and financial audits help the government to assess the financial management of project funds and are to be carried out by the Royal Audit Authority. These audits must be conducted in accordance with International Standards on Auditing and cover all aspects of the project activities, including review of the eligibility of expenditures and the actual verification of the goods and services financed. The report must also review compliance with procurement procedures, compliance with financial reporting requirements and consistency between financial statements, management reports and field visits (including concrete verification).

IX. STAKEHOLDERS´ ROLES AND RESPONSIBILITIES

9.1. Steering Committee

MOH must set up a Steering Committee, which will meet twice a year, to oversee the implementation of the project at the national level. The SC is responsible for:

- Providing overall policy guidance
- Ensure inter-departmental (within MOH) and inter-ministerial coordination and accountability for results;
- Overseeing progress of the project at least once every six-months and provide guidance for any remedial actions for improved performance;

The SC is composed as follows:

- Secretary, Ministry of Health
- Director, Department of Public Health, Ministry of Health
- Representative, Department of Health Services, Ministry of Health
- Representative, National Medical Services
- Representative, Department of Macro-Fiscal and Development Finance, Ministry of Finance
- Representative, Department of Local Governance and Disaster Management, Ministry of Home Affairs

9.2. Project Management Unit at MOH

At the central level, the project management is under the responsibility of a Project Management Unit (PMU) under the Department of Public Health (DoPH), in particular the Reproductive Maternal Newborn Health Program (RMNHP), under the Non-Communicable Disease Division (NCDD).

The PMU is responsible for planning, coordination, monitoring and evaluation, performance tracking, financial management, procurement, social & environmental management, effective record keeping and data management systems, and progress reporting all project activities in close collaboration with other departments of the MOH.

All PMU staff must get well acquainted with all the strategic documents for the AMCHP, including Project Paper (PP), Grant Agreement (GA), Project Operations Manual (POM), Project Procurement Strategy Document (PPSD) and the Environmental and Social documents.

9.3. Health Facilities

Women in Bhutan may attend ANC and PNC visits and deliver at the facility of their choice. Each level of health facility (regional and districts hospitals, PHCs and outreach clinics) is therefore participating and has a role in the implementation of the project.

Health facilities are responsible for:

- Delivering services to women and children; both directly and through outreach services.
- Recording the first booking and information related to all visits in the DHIS2.
- Enrolment in the TIS and project information pertaining to all subsequent visits.

HAs are responsible for registering and enrolling PLWs in the project after the first booking. This includes:

- Communicating to the PLWs basic information about the project, and about the registration and enrolment process.
- Creating a profile in the TIS for the PLW, with the basic relevant data, and checking identification numbers and documents.
- Entering the relevant welfare data in the TIS in order calculate the eligibility score of the PLW, which determines whether she may be enrolled as a CCT beneficiary or not.
- Explaining the conditions of the project to the potential beneficiary.
- Supporting the beneficiary in opening a bank account, in case she does not already have one.
- Providing the services as per the MNCH guideline.

Since compliance with conditionalities relies on data provided by the HAs, and since this has a direct implication on CCT payments and possible suspensions of transfers, HAs are required to enter the data on the same day that visits are made; ideally, at the time of the visit.

9.4. Dzongkhag Health Officers

The DHOs are responsible for overseeing the implementation of the project in their Dzongk, including:

- Training of HAs.
- Sensitization of the LG functionaries on the general objectives and rules of the project.
- Training of LG functionaries on their role in the GRM.
- Support the HAs in the registration and tracking process
- Supervise implementation of GRM.

9.5. GovTech

GovTech is responsible to ensure that the TIS is functioning well, with data entered at sub-national levels. A specific MOU describes the responsibilities of GovTech in the project implementation and the agreements reached with the MOH.

9.6. Local Governments and Functionaries

Local government representatives are responsible for communication and outreach activities at village level. LG functionaries consist of Gups, Mangmi and Tshogpa, and GAO among others. They have the following key responsibilities:

- Communication and outreach activities in their respective gewogs/villages.
- Following up on non-compliance of beneficiaries and encouraging beneficiaries to attend all of their scheduled appointments.
- Facilitating lodging complaints in the TIS, on behalf of beneficiaries and in accordance with the GRM rules.
- Providing recommendations on the resolution of complaints.
- Following up on the resolution of the complaints and communicating the outcome to the beneficiaries.

9.7. Village Health Workers

Village Health Workers have the following key responsibilities:

- Providing information to the general community on the project and its benefits.
- Reaching out to beneficiaries, as requested by HAs, in case of non-compliance with the project conditionalities.

9.6. Bank of Bhutan

BOB plays an essential role in the project. It is responsible for opening accounts to newly enrolled beneficiaries, in case they don´t already have one, and for making the CCT payments every month.

The responsibilities of BoB and the agreements reached with the MOH are described in a Memorandum of Understanding.

Annex 1: AMCHP Results Framework

Project Development Objective (PDO): Enhance utilization of maternal, neonatal, child health and nutrition services (MNCHN) by pregnant and lactating women (PLW) in all districts of Bhutan.

#	PDO Result Indicators	Unit	Baseline	End Target
P.01	Increase in antenatal care	%	(tbc)	20%
P.02	Increase in postnatal care	%	(tbc)	20%
P.03	Compliance with (at least 50%) of scheduled visits	%	(tbc)	75%
P.04	Increase in pregnant women screened for pre-existing conditions	%	(tbc)	20%
P.05	Increase in dietary diversity (by 15%) among CCT beneficiary households	%	(tbc)	75%
#	**Intermediate Result Indicators**	**Unit**	**Baseline**	**End Target**
I.01	PLW registered in the TIS	number	0	30,000
I.02	PLW registered for CCT	number	0	10,000
	➢ who are receiving financial and digital literacy information	number	0	9,000
I.03	PLW receiving CCT living in households from the lowest quintile of the welfare distribution	%	0	75%
I.04	National media campaign events	number	0	6
I.05	Local government leaders trained	number	0	500
I.06	ORCs undertaking SBCC	number	0	500