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Project Information Document (PID)

Appraisal Stage | Date Prepared/Updated: 21-Dec-2020 | Report No: PIDISDSA31205

BASIC INFORMATION

A. Basic Project Data

Country	Project ID	Project Name	Parent Project ID (if any)
India	P173958	Mizoram Health Systems Strengthening Project	
Region	**Estimated Appraisal Date**	**Estimated Board Date**	**Practice Area (Lead)**
SOUTH ASIA	25-Nov-2020	12-Mar-2021	Health, Nutrition & Population
Financing Instrument	**Borrower(s)**	**Implementing Agency**	
Investment Project Financing	Sameer Kumar Khare	Shri H. Lalengmawia	

Proposed Development Objective(s)

Project Development Objective (PDO) is to improve management capacity and quality of health services in Mizoram.

Components

Component 1. Strengthen management and accountability through Internal Performance Agreements (IPAs)
Component 2: Improve design and management of state health insurance programs.
Component 3: Enhance quality of health services and support innovations.
Component 4: Contingent Emergency Response Component.

PROJECT FINANCING DATA (US$, Millions)

SUMMARY

Total Project Cost	32.00
Total Financing	32.00
of which IBRD/IDA	32.00
Financing Gap	0.00

DETAILS

World Bank Group Financing

International Bank for Reconstruction and Development (IBRD)	32.00

Environmental and Social Risk Classification

Moderate

Decision

The review did authorize the team to appraise and negotiate

Other Decision (as needed)

B. Introduction and Context

Country Context

1. **India is one of the fastest growing economies of the world but the gross domestic product (GDP) growth has slowed in the past three years, and the Coronavirus Disease 2019 (COVID-19) outbreak is expected to have a significant impact.** Growth has moderated from an average of 7.4 percent during fiscal year (FY) 15/16-FY18/19 to an estimated 4.2 percent in FY19/20. The growth deceleration was due mostly to unresolved domestic issues (impaired balance sheets in the banking and corporate sectors), which were compounded by stress in the non-banking segment of the financial sector, and a marked decline in consumption on the back of weak rural income growth. Against this backdrop, the outbreak of COVID-19 and the public health responses adopted to counter it have significantly altered the growth trajectory of the economy, which is now expected to contract in FY20/21. On the fiscal side, the general government deficit is expected to widen significantly to over 10 percent of GDP in FY20/21, owing to weak activity and revenues as well as higher spending needs.

2. **Since the 2000s, India has made remarkable progress in reducing absolute poverty.** Between FY11/12 and 2015, poverty declined from 21.6 percent to an estimated 13.4 percent at the international poverty line (US$1.90 per person per day in 2011 Purchasing Power Parity (PPP)), continuing the earlier trend of rapid poverty reduction. Owing to robust economic growth, more than 90 million people escaped extreme poverty and improved their living standards during this period. Despite this success, poverty remains widespread. In 2015, 176 million Indians were living in extreme poverty, while 659 million—half the population—were below the higher poverty line commonly used for lower middle-income countries (US$3.20 per person per day in 2011 PPP). The COVID-19 outbreak is likely to further moderate the rate of poverty reduction and risks people falling back into poverty.

3. **In the past decade, the health sector has witnessed major reforms especially in-service delivery and financing.** The National Health Mission has increased the states' fiscal space for investments in health services and has established mechanisms for accountability between the center and states through annual project implementation plans and budgets. Additionally, the 14th Finance Commission recommendations increased the share of central tax devolution (from 32 percent to 42 percent) providing states with greater flexible funds to finance their priorities. The Ayushman Bharat-Pradhan Mantri Jan Arogya Yojana (AB-PMJAY) provides protection against hospitalization expenses for poor households, covering 40 percent of India's population.

4. **Mizoram is part of the North East region, geographically isolated with a distinct identity.** This landlocked state, established in 1987, has 3 autonomous Hill Councils covering all 8 Districts and 23 Blocks. The state has a population of 1.09 million with 92 percent literacy and around 95 percent belonging to the category of scheduled

tribes.[1] About 20% of the households live below the poverty line.[2] While 48 percent of the population is rural, another 37 percent resides in the capital city Aizawl alone, and urbanization is increasing.[3] The state's economy has grown consistently, primarily driven by the service sector, with considerable fiscal dependence on the central government. Per capita income in Mizoram in 2018-19 was US$1,708 (INR 168,626), 33 percent higher than the national figure.[4] Only 10 percent of the state government's revenue is from local revenue collection, with the remainder dependent on fiscal transfers from the central government.

Sectoral and Institutional Context

5. **Mizoram's performance on key health outcomes is mixed when compared to national averages, with significant urban-rural disparities and an increasing burden of non-communicable diseases (NCDs).** In 2014-15, the total fertility rate of 2.3 in Mizoram was similar to the rate of 2.2 nationally; under-five mortality in Mizoram was 46 per 1,000 live births, compared to 50 nationally; and the prevalence of stunting among under-five children was 28.1 percent, compared to the national figure of 38.4 percent. At the same time, there are significant rural-urban disparities in Mizoram: under-five mortality in rural areas was 58 per 1,000, compared to 35 in urban areas; and prevalence of child stunting was 33.7 percent in rural areas, compared to 22.7 percent in urban areas.[5] NCDs account for more than 50 percent of the disease burden in the state,[6] while Mizoram is estimated to suffer from the highest prevalence of cancer in the country.[7]

6. **Government health spending is comparatively high, although out-of-pocket spending/expenditure on health services by households remains significant.** Health expenditure as a share of total state government expenditure in 2015-16 was 8.3 percent, highest among the North Eastern states and second highest nationally. At US$84 (INR 2,872) per capita, government health spending in Mizoram in 2015-16 was highest in the country, where the national average was US$16 (IN 1,112).[8] The state budget estimate for health in 2020-21 is US$89 million (INR 626 crores).[9] Nonetheless, out-of-pocket expenditures by households for health services are significant. In 2017-18, a hospitalization episode costed patients in Mizoram an average of US$188 (INR 12,109), although this is significantly lower than the national average of US$312 (INR 20,135).[10]

7. **The government health system encompasses services from the primary to hospital levels.** The Department of Health and Family Welfare (DoHFW) includes two Directorates. The Directorate of Medical and Public Health (DMPH) is responsible for public health functions and primary health care services provided by 9 Community Health Centers, 58 Primary Health Centers, 372 Sub-Centers and 171 Clinics. The Directorate of

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[1] Census 2011
[2] https://planning.mizoram.gov.in/uploads/attachments/e69d83919b9a45a04e7252f58f106bf6/mizoram-vision-2030.pdf
[3] Singh AK (2017) Urbanization in Mizoram: Characteristics and Correlates. The Geographer 64(1): 21-31.
[4] Economic Survey of Mizoram 2019-20, Government of Mizoram
[5] International Institute for Population Sciences (IIPS) and ICF. 2017. National Family Health Survey (NFHS-4), 2015-16: India.
[6] Indian Council of Medical Research, Public Health Foundation of India and Institute for Health Metrics and Evaluation. 2017. India: Health of the Nation's States – The India State-Level Disease Burden Initiative. Mizoram: Disease Burden Profile, 1990 to 2016.
[10] Government of India. 2019. National Health Profile 2019, 14th Issue. Central Bureau of Health Intelligence, Ministry of Health and Family Welfare.
[7] Three-year report of population-based cancer registry 2012-14, Indian council of medical research. http://ncdirindia.org/NCRP/ALL_NCRP_REPORTS/PBCR_REPORT_2012_2014/ALL_CONTENT/PDF_Printed_Version/Chapter1_Printed.pdf
[8] National Health Profile 2019, CBHI, Ministry of Health and Family Welfare, Government of India.
[9] Mizoram Budget documents – 2020-21, Department of Finance, Government of Mizoram
[10] IIPS and ICF. 2017; Government of India. 2019b. Key Indicators of Social Consumption in India: Health – NSS 75th Round (July 2017-June 2018). Ministry of Statistics & Programme Implementation. National Statistical Office.

Hospital and Medical Education (DHME) manages 9 District Hospitals, 5 Sub-District Hospitals, and one medical college. While the state meets national facility-to-population norms, more than half of the government hospitals are concentrated in the most urbanized Aizawl district, while the dispersed population and hilly terrain in rural areas impede geographic access to services. Nonetheless, because most private health care providers are in the larger urban centers, the state population is more dependent on government health services than is usual in the rest of India. The DoHFW at the state level is responsible for all policy formulation, financing and oversight. DMPH and DHME are responsible for providing technical leadership and administrative control of service delivery units in the state. In addition to the two Directorates at the state level, the State Health Society provides stewardship and financing for almost all public health services, outreach and interventions, and for systems strengthening interventions. Also, the state insurance agency provides financial protection against hospitalization costs through the insurance program. Most of the procurement and infrastructure repair and maintenance functions are managed at the state level, with limited flexibility to the districts and service delivery units for local procurement.

8. **While Mizoram performs well on a composite measure of health system performance, there are challenges due to fragmented structures and weaknesses in planning, budgeting, management and monitoring of resources, directly affecting service delivery.**

- Financing channels and accounting systems are fragmented at the state, district and facility levels. The budget process shows weaknesses in planning and utilization of resources; for example, in the period 2016-18, the Directorate of Medical and Public Health spent 80-85 percent of its revised budget estimates.[11]
- Service delivery operations and their management are fragmented between the two directorates, resulting in lack of efficiency gains. Weak capacity for indenting for medicines, weak demand forecasting capacity lead to sub-optimal planning and budgeting for medicines causing medicine stock-outs. Directorates do not have enough Human Resource information to project human resource requirements leading to critical vacancies. No bio-medical waste management committees at the state and district levels and very weak inter-governmental coordination lead to weaknesses in infection control and therefore patient safety. The Quality Assurance (QA) program is another area where lack of accountability causes large backlogs for the QA assessors' team and resources deployed for this purpose.

9. **Further, the coverage, management capacity and financial sustainability of the Mizoram State Health Care Scheme (MSHCS) remain a key challenge.** The MSHCS started in 2008, is free-of-charge to households below the poverty line and costs US$14 (INR1,000) for enrolment by households above the poverty line. Number of beneficiaries enrolled under the state scheme is 2018-19 was 112,732. With the launch of the central government's AB-PMJAY program in 2018 in Mizoram, the state is implementing two parallel schemes. Each scheme has its own benefit package though the packages and the exclusion criteria are similar. Both the state and central schemes are managed by the same state insurance agency. Coverage of the scheme and enrolment is a challenge, with only about 55% of eligible beneficiaries enrolled. Low beneficiary awareness is a major demand side challenge. There is a need for technical support on converging the schemes, increasing coverage, and improving its management and efficiency.

10. **Other important gaps that result in sub-optimal utilization and delivery of health services in the State.**

[11] Demand for Grant, Health and Family Welfare Department, Government of Mizoram.

- Gaps in human resources: In 2017, there were 437 doctors in government service in the state, with no specialists working in Community Health Centres (CHC).[12] In 2017-18, 16 percent of specialist positions in District Hospitals were vacant, while 20 percent of auxiliary nurse-midwife positions in Sub-Centers were vacant. The absence of a robust health human resource strategy and weak management policies and systems continue to pose challenges.
- Inadequate supply of medicines: The medicines initiative is hampered by a lack of timely consumption data to inform planning, leading to inadequate and inappropriate supply. Weak procurement and supply chain management systems, along with poor intra-departmental coordination, lead to purchasing of high-cost medicines. Lack of medicines and diagnostic services in government hospitals lead to out-of-pocket spending by patients.
- Quality improvement of health facilities: Only two hospitals have received National Quality Assurance Standards (NQAS) Certification in 2017. Although, the state has successfully implemented a national health care hygiene program (*Kayakalp*), the efforts require additional technical support and investment particularly in rural areas. Sub-optimal financing of bio-medical waste management activities, weak structure to provide oversight on regulatory compliance, lack of training on segregation of waste at source, on waste transportation, disposal and treatment further accentuate the problem. This challenge assumes more serious proportions in the post-COVID 19 world and has a direct impact on patient safety and quality of care they receive.

11. **Like other states in India, the pandemic and lock-down measures in response have had adverse effects on the delivery and utilization of essential health services.** As of September 19, 2020, there were only 1,548 COVID-19 cases diagnosed in Mizoram, lowest among all states in India, with no COVID-related deaths reported.[13] Due to the pandemic and the associated periods of lockdown, coverage of ante-natal care in April-June 2020 was 5 percent lower compared to the same period in 2019; there were 18 percent fewer deliveries in government health facilities, 10 percent fewer deliveries in private health facilities, and 28 percent fewer cesarean sections. Child immunization coverage declined by between 28 and 40 percent. In-patient services and surgeries were reduced by between one-third and one-half.

12. The proposed project aims to create an enabling environment and build health systems management capacity in Mizoram for a more resilient response to future outbreaks, pandemics, and health emergencies. It will do so through investments in infection prevention and control, effective handling of biomedical waste, strengthening the human resource that is at the forefront of any health systems response, ensuring maximum coverage of population under a strengthened health insurance program to ensure financial protection against hospitalization costs. It is pertinent to note that under the national PMJAY scheme, the National Health Authority has integrated COVID-19 related testing and treatment packages under the scheme, and strengthening the scheme at the state level will directly improve COVID-19 related testing and treatment in the state

C. Proposed Development Objective(s)

Development Objective(s) (From PAD)

[12] Government of India. 2019a.
[13] https://www.covid19india.org (The national COVID-19 program has provided funding of US$0.51 million (INR 3.71 crores) to Mizoram to support its preparedness and response in the areas of diagnostics, infection control, patient and health worker safety, contact tracing, quarantine, case management and communication. The state formed a task force, developed a contact tracing system, established quarantine facilities, and supplemented health services with medical equipment and human resources.)

Project Development Objective (PDO) is to improve management capacity and quality of health services in Mizoram.

Key Results

Following indicators will be used to measure the achievement of the PDO:

PDO level result indicators	Management capacity	Quality
The percentage point increase in average performance score in targeted administrative units as per internal performance agreement from baseline.	✓	
Cumulative Number of districts hospitals which are NQAS certified.		✓
The percentage point increase in average quality index score for CHCs and PHC from baseline.		✓
The percentage point increase in score among those who participated in clinical vignettes.		✓
Improve management and efficiency of Health insurance program by Convergence between the MHCS and AB-PMJAY.	✓	

D. Project Description

13. **The project is supported by an IBRD loan of US$32 million using an Investment Project Financing (IPF) instrument and is structured in four components.** The project will follow principles agreed with Ministry of Health and Family Welfare (MOHFW) and Department of Economic Affairs (DEA) where it will not duplicate with existing activities of the state health system and National Health Mission (NHM) and not set up a parallel monitoring system. Rather, the project will support and complement existing health systems, including HMIS and other implementation mechanisms involved at different levels, under the NHM. The first three components of the project address different elements of the PDO (management capacity and quality) while the fourth will be a Contingent Emergency Response Component (CERC).

14. **Component 1. Improving management and accountability, and strengthening governance through Internal Performance Agreements (cost US$ 13.5 million):** This component focuses on reforms in governance and management structures to increase and accountability using through IPA tool that will be signed between the DoHFW and its subsidiaries at the state and sub-state levels. A results-based financing (RBF) approach is expected to strengthen the management and accountability relationships between state and the sub-state level implementing units. Fund transfers to institutions and health facilities would be made against the achievement of performance indicators specified in IPAs. Distinct performance metrics are designed for various levels as per their roles and responsibilities that contribute to enhanced access to and quality of health services. The State level indicators (for Directorates) are to improve timely resource allocation to districts and health facilities, policy reforms in HR and their deployment, ensure procurement and supply of drugs and medical equipment as per need. District level performance indicators contributes to improved monitoring and supervision, coordination support for supply of drugs, institutional level review for bio-medical waste and facilitation of quality improvement and accreditation processes. At the health facility levels performance indicators are targeted to improve quality of service delivery including content of care quality, patient satisfaction, satisfaction and user experience of women patients, bio-medical waste implementation, reporting and documentation and to improve clinical skills of the medical staff.

15. **Component 2: Improve design and management of Health insurance programs (US$ 2.5 million):** This component supports the state insurance program and its linkages with the PM-JAY to reduce financial barriers in accessing hospital services, prevent catastrophic out-of-pocket expenditures (OOPE) for health by poor families, and expand coverage. The project will finance investments in such corrections at three levels: (a) strengthening policy and design for increased operational efficiency; (b) strengthening institutional capacity, systems and processes of the State insurance agency for greater accountability: The project will support investments in IT architecture and capacity to convert the state scheme (MHCS) into a paperless transaction system like the central scheme (PM-JAY), and to improve other functions such as beneficiary identification, hospital empanelment, referrals, portability mechanisms, claim adjudication, financial management, grievance redressal, service quality audits, and monitoring; and (c) community interventions for improving coverage and demand. Comprehensive communication campaigns and demand side interventions will be supported to improve enrolment under the schemes and increase demand for services.

16. **Component 3: Quality of health service and innovations (US$ 16 million):** This component focuses on improving the quality of care through a comprehensive quality assurance for health service; augmenting systems related to human resource management, bio-medical waste management, procurement and supply chain, and project management capacity. This will be achieved through input based financing at District hospitals, CHCs and PHCs to achieve National Quality Assurance Standards (NQAS) certification, developing a robust HR policy; focussed skill building of health cadres; and piloting initiatives that can help the state improve the effectiveness of interventions. These efforts will also lend to strengthening the capacity of facilities to respond to increasing disease incidence due to enhanced climate vulnerabilities. The project will also design interventions focused on making health facilities environmentally friendly and energy efficient (use of solar power, conserving water resources through rainwater harvesting and landscaping). Strong efforts to improve the biomedical waste will also be undertaken. On the HRH front, apart from addressing the issue of shortage of human resources in the state with comprehensive state Human Resource policy in place, the project will also support improvements in pre- and in-service training, including quality accrediting for college of nursing, revamping training institutions and nursing schools and developing programs for continuing medical and para-medical education. In addition, the project will emphasize capacity building of hospital and health facility staff, focusing on techno-managerial skills and aligning incentives to perform better, through the medium of innovative in-service trainings and by piloting performance-based incentives and rewards. The project will implement 'Low Dose High Frequency (LDHF) Training' approaches. These approaches will implement specific 'vignettes' or knowledge tests to promote evidence based medical practice targeting key conditions related to the burden of disease in Mizoram. Certain innovations will also be piloted under the project including use of telemedicine and tele-diagnostics and use of drone technology for assisting in delivery of blood and other similar essential lifesaving medicines. The project will also leverage the strong community systems to pilot models for cancer screening and palliative care services (which are currently at nascent stage) in two districts.

17. **Component 4: Contingent Emergency Response Component (US$0 million)**: The CERC component provides a mechanism for provision of immediate response to an Eligible Crisis or Emergency, as needed.

Legal Operational Policies

	Triggered?
Projects on International Waterways OP 7.50	No
Projects in Disputed Areas OP 7.60	No

Summary of Assessment of Environmental and Social Risks and Impacts

18. **The Project will follow the World Bank's Environmental and Social Framework (ESF), which consists of ten Environment and Social Standards (ESS).** From the likely activities of the proposed investment, the E&S risk is classified as moderate. The project will support strengthening of health systems for human capital development in Mizoram. The relevant E&S standards are: ESS1 - Assessment and Management of Environmental and Social Risks and Impacts, ESS2 - Labor and Working Conditions, ESS3 - Resource Efficiency and Pollution Prevention and Management, ESS4 - Community Health and Safety, ESS7: Indigenous Peoples/Sub-Saharan African Historically Underserved Traditional Local Communities and ESS10 - Stakeholder Engagement and Information Disclosure.

19. Project activities and interventions will improve management and accountability of the healthcare system in the State by strengthening the structure and system associated with health care delivery, enhancing capacities of healthcare providers and healthcare managers, integrating and improving the health management information system and improving the quality of and access to health services. In hard-to-reach and remote areas, community-driven and public-private partnership approaches will be introduced to ensure access to and quality of healthcare services.

20. While most of the interventions have positive social impacts, the key social risks emerge from risk of exclusion and access to services by vulnerable populations in remote and hard to reach areas; risk to occupational and health safety issues from repair and renovation activities of health facilities – though small in nature but at dispersed locations. The project does not anticipate any land acquisition and/or involuntary resettlement as the infrastructure improvement activities are limited to repair, renovations, and minor expansion within the existing footprint of the health facilities.

21. With the improved utilization of health services through the project, the quantity of bio-medical waste is expected to increase incrementally. Any improper management of wastes including bio-medical waste, and other hazardous wastes such as plastic waste, e-waste etc poses environmental risks. However, the project plans to invest in improving the overall ecosystem for bio-medical waste management (both solid and liquid waste wastes) in the State that includes segregation, disinfection, collection and disposable that largely safeguards the environment and contributes in improving the quality of health service and patient safety. The ESMF further provides for management of other hazardous wastes and waste generated due to infrastructure repair and retrofitting of the health facilities.

22. To mitigate these risks, the DoHFW has prepared an Environment and Social Management Framework (ESMF) that will guide the project to address the adverse environmental and social risks and impacts. The ESMF mandates that screening will be conducted for each of the subprojects (once they are selected) to avoid any adverse social impacts including potential impacts on informal/ illegal settlers residing within the health facility premises/ land (if any). Based on the E&S screening, further sub-project specific ESIAs and ESMPs will be prepared during the implementation of the project. Concerns and needs of the vulnerable groups (including issue of access and exclusion, occupational health and safety, and stakeholder engagement and grievance redressal etc.) will be addressed through following interventions: (a) prioritizing the HCF in backward in difficult to reach, remote and hilly areas, and identifying the key barriers in accessing health services along with building awareness; (b) strengthening and devising exclusive awareness campaigns to

educate and sensitize the poor and vulnerable on health seeking behaviour through social and behaviour change communication (SBCC); (c) instituting measures for occupational health and safety in line with World Bank EHS guideline and Government or India norms; and (d) strengthening the grievance redress mechanism.

23. As part of the ESMF preparation and to inform project design, consultations with key stakeholders, including the concerns and requirements of the vulnerable and disadvantaged communities are sought through virtual consultations with representative organizations/ institutions including NGOs/ CBOs working with these communities. Further, mechanisms to incorporate their concerns and needs in the project implementation in a continued manner and ways to engage them during the project implementation is detailed out in Stakeholder Engagement Plan (SEP). The SEP identified and analyzed the project's key stakeholders and interested parties including officials from DOHFW, various line departments/ agencies, Autonomous Development Councils, NGOs/ CBOs, traditional leaders, and health service providers; outlined a strategy for engagement; and assessed existing grievance redress mechanisms (GRMs) and information disclosure channels, as well as provision of the necessary measures for addressing identified gaps. The key concerns of the stakeholders arise from: (a) lack of doctors mainly the specialists and nurses, (b) quality of care including community awareness about quality, (c) limited engagement and awareness about health facility committees etc. The SEP has set a systematic and inclusive approach for communication and information sharing that will be followed by the different groups of stakeholders. This is in turn expected to contribute to minimizing the potential social risks and impacts of the project and redressal of grievances and concerns. The ESCP, sets out a timeframe of measures and actions to ensure that potential adverse project risks and impacts are avoided, reduced, or mitigated. The SEP will be disclosed prior to appraisal along with ESMF.

24. The project's sexual exploitation and abuse (SEA) and sexual harassment (SH) risk has been rated as low as the project will not include any major civil works. However, given that the State has prioritized women in their programs and schemes, and gender based violence is one of the important areas that the state plans to address, the health professionals and health systems play an important role in caring for survivors of sexual violence, it is important to build capacity of health care professionals by sensitizing them to SEA and SH issues and measures as part of their training, and address mandatory provisions of 'The Sexual Harassment of Women at Workplace (Prevention, Prohibition and Redressal) Act, 2013' in DOHFW and in project facilities.

25. The existing DoHFW governance and management structures and departments will be used for project implementation. The DoHFW will house the Project Management Unit (PMU) of the project and that will have social and environmental specialists who will be responsible for overseeing the implementation of E&S activities including monitoring and reporting aspects. At the health facility level, the Medical Officer (MO) in charge will be responsible for environmental and social due diligence under the guidance of Chief Medical Officer (CMO) at the district level.

26. **CLIMATE CHANGE:** The climate and disaster risk screening tool was used to assess the climate and disaster risks to the project. Given extreme precipitation, flooding and geophysical hazards (lies in seismic zone 5, prone to earthquake) are identified as key hazards for the project location and project beneficiaries, the project is assessed as Moderate risk. The proposed interventions under the project are designed to have a positive impact on the lives of beneficiaries through health system strengthening initiatives—at state, district, health facility and community level —these interventions will improve the quality of the service delivery in light of aforementioned hazards and improve the coping capacity of the health system when faced

with an extreme event. The project includes several climate adaptation and mitigation measures to address the health-related vulnerabilities: (i) Supporting the NQAS accreditation process which include comprehensive plan for biomedical waste management (including segregation, collection, treatment, and disposal) as a critical element of infection control and to minimize negative impacts to the ecosystem and reduce population risk of exposure to diseases caused by unsanitary environment; use of energy-efficient bulbs for lighting; availability of power backup in health facilities, as measures to reduce energy requirements while improving efficiency; (ii) The retrofitting and upgradation of health facilities will explore opportunities to use solar power as a clean and efficient energy source. Renovation of infrastructure will follow the principles of energy efficient building; (iii) The HRH component includes capacity building of the health workers to improve the coping capacity of the health system when faced with an extreme event. This will also address issues arising out of climate change and pandemic.

27. **CITIZEN ENGAGEMENT:** The project includes several initiatives aimed at strengthening citizen engagement and improving the health system accountability mechanism. These include (1) capacity building of the administrative and service delivery staff to facilitate change management and effective use of information systems; (2) strengthening facility level health management committee with community representative implementing their facility development plans; (3) awareness building on state health insurance scheme , and other aspects of health services under the project; (4) using community engagement indicators as part of the HCFs internal performance measurement score under performance based financing, and that includes (a) displaying citizen charter, (b) adopting administration of patient rights forms to all in-patient admission and invasive procedures, and (c) patient engagement through enhancing patient counselling on non-communicable diseases (NCD); (5) support establishment of systems for effective community engagement, particularly involving women representatives at the local level, including in planning, decision-making, and monitoring of the services of target Health and Wellness Centre (HWCs).

28. Overall preparation risk is rated as Substantial. Although some of the activities to be supported by the project are new to the state government, the required institutional basis is in place and functioning. Substantial implementation risks largely stem from currently insufficient systems, experience and capacities for implementation, as well as risks of misuse of public funds for purposes other than those intended. These risks will be mitigated by contracting a Project Management Agency as well as ensuring clarity on implementation procedures. The detail risk and mitigation measures are mentioned below.

E. Implementation

Institutional and Implementation Arrangements

29. **The Department of Health and Family Welfare (DoHFW) will be responsible for the implementation of the project.** The existing DoHFW governance and management structures will be used for project implementation. A Project Steering Committee (PSC) under the Chairmanship of the Chief Secretary will provide oversight to the project. The Committee will also include Principal Secretary, Health and Family Welfare and Secretaries of other relevant departments. The Committee will oversee the project implementation and results and will be responsible for approving and monitoring the annual project plans and budgets and for preparing the Project Operations Manual. The Principal Secretary, Health and Family Welfare will lead the Project Executive Committee (PEC) to provide regular monitoring and necessary approvals for day-to-day implementation of project activities. Given the results focus of the project, which

requires coordinated action by directorates within the DoHFW, the designation of a senior official within the department is critical to effective implementation.

30. **The Principal Director, Health will be the Project Director and will lead the Project Management Unit (PMU).** The PMU will be responsible for the project implementation, including its regular monitoring and supervision. The PMU will have staff deputed from the two directorates - (i) Directorate of Health Services; and (ii) Directorate of Medical Education. Approximately 10 staff and consultants will be included in PMU and will be responsible for procurement and financial management, social and environmental safeguards as well as technical areas including community mobilization, quality assurance, monitoring, IEC, HRD and a civil engineer. A Technical Assistance Provider will be setup to augment the PMU's capacity in administrative and technical areas including procurement, financial management, hospital quality improvement, management of information systems and other technical areas. Technical and knowledge partnerships as well as multi stakeholder engagement will be established to augment technical capacity of the department.

31. **PMU will develop the Operations Manual (OM) that will provide guidelines and procedures to be used for implementation of the project.** The OM will also define the scope and technical specification of the project activities along with the monitoring system. The procedures for administrative approvals and financial controls will also be well defined to minimize ambiguity and bring efficiency in implementation of the project.

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APPROVAL

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