Republic of India
Health, Nutrition and Population Technical Assistance to North East States (India)

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GHNDR
SOUTH ASIA
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Summary
Health, Nutrition and Population Technical Assistance to North East States

India

Non-Lending Technical Assistance (P146929)

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Health, Nutrition and Population Global Practice (GHNDR)
South Asia Region
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1. Background and Objective

The eight states in India’s North-East region are connected to the rest of the country by a narrow corridor and (until recently) were classified by the Indian government as “special category” states. As such, they are a particular focus of the World Bank's Country Partnership Strategy for India (2013-17) (Report No. 76176). This non-lending technical assistance (NLTA) was requested by the governments of Nagaland and Meghalaya, stemming from previous engagements with the World Bank Group – the state HIV/AIDS program (supported by IDA financing) in the case of Nagaland, and IFC advisory services for private sector involvement in government health insurance program and investment in medical education in the case of Meghalaya. Both state governments show commitment to improving health and nutrition services and outcomes and look to the World Bank to provide support.

The majority of the populations of Nagaland and Meghalaya, totaling two and five million respectively, are from tribal communities. The per capita gross domestic product of both states is about US$ 1,100, lower than the national figure of US$ 1,350. Household survey results for both states released a few months ago show that while there has been progress in improving health services over the past decade, considerable challenges remain. For example, in Nagaland in 2012-13, only 36% of one-year-old children had received all recommended vaccinations; while this was an improvement from 21% in 2005-06, it is far below the 2009 national average of 61% (itself very low). In Meghalaya, this indicator was 49% in 2012-13, better than the 33% measured in 2005-06 but also significantly lower than the national average. In both states, the population depends on government health services to a significantly greater extent than elsewhere in India.

In each state, 70-80% of the population live in rural areas, dispersed over a large number of small villages. The topography of both states is hilly, with poor roads and connectivity. This raises significant barriers to effective service delivery and access to services. At the same time, there are problems with how health services are organized, managed and delivered. Like in India as a whole, since 2005 the National Rural Health Mission (now known as the National Health Mission) has provided channeled significant central
government resources and technical input for improvements in government health services in the two states. The state governments requested the Bank for technical assistance in specific areas for which other sources of support, particularly the National Health Mission, were not available, and improvements in which held the potential to leverage the effectiveness of existing government financing.

The development objective of this activity is to support development of health system strategies, policies and management systems in North East states.

2. Implementation

In May 2013, the Department of Economic Affairs (DEA) of the Ministry of Finance endorsed and transmitted to the Bank requests for technical assistance from the two state governments. Implementation was planned over FY14 and FY15, with planned final delivery in May 2015. A cross-sectoral team worked on this activity, including specialists in health, community development, renewable energy and water and sanitation. The Bank team ensured ongoing dialogue with each state government, defined requirements in each technical area, managed consultants, ensured quality, and followed-up with dissemination and policy dialogue. In each technical area, consultant firms/organizations were competitively selected to complete the necessary assessments, recommendations, plans, specifications and budgets. Ongoing in-person dialogue with state government officials, along with a series of workshops in each state and in Delhi, as well as two lunch-time BBLs at the World Bank in Delhi (attended by Bank staff, DEA, consultants and other stakeholders), provided for dissemination of results and feedback from and dialogue with stakeholders.

In December 2013, DEA endorsed a request for an investment project from the Nagaland state government, so that the NLTA work focused on Nagaland contributed to technical preparation of the project.

3. Outputs

The concept note included work in the following areas:
- Cross-sectoral strategies to improve health and nutrition;
- Health human resource analysis and planning;
- Design of procurement and supply chain management system;
- Information and communication technology (ICT) system design;
- Results-based financing (RBF) strategy design; and
- Just-in-time support.

Based on further understanding of state government requirements and demand, planned work on cross-sectoral strategies came to encompass substantial technical work on off-grid energy and water/sanitation for health facilities in Nagaland, as well as on Nagaland’s system of community management of health services. Planned work on human resources, supply chain management and ICT, was done in both states as planned. Planned support to an RBF strategy for hospital services in Meghalaya did not
move forward, although an RBF strategy was incorporated in a recommended plan to support the community level in Nagaland. On-demand, just-in-time support, was provided to the government of Nagaland on design and quality assurance of health facility and household surveys.

a. Off-grid energy for health services

Nagaland requested technical support on power supply for health services, as this was perceived as affecting the quality of services, patient demand and working conditions for health workers. Indeed, an assessment of 24 facilities found that 18 experienced power cuts of 12-18 hours per day, while 1 had power cuts of more than 18 hours. None of the facilities had grid power supply for more than 18 hours. The assessment found that unreliable power affected service delivery, both directly by cutting lighting and making equipment inoperable, and indirectly by influencing equipment purchase and allocation decisions (i.e. contributing to the fact that health facilities in the state are under-equipped in relation to national standards.). Different categories of health facilities were developed based on current and future anticipated power demand, informing recommendations for investments. In larger facilities, (Primary Health Centers, Community Health Centers and District Hospitals) it was recommended to use solar energy technology, combined with diesel generators to meet needs in poor solar conditions. (A number of facilities already have generators installed, but they are not often used due to lack of budget for fuel). Smaller facilities, particularly Sub-Centers, can function with battery and inverter systems that can be charged by the grid when it is available. Analysis of solar energy potential in Nagaland concludes that it is a cost-effective option, with only 20% lower potential than locations receiving high solar energy such as Gujarat or Rajasthan. At the same time, considering the low cost to the user (i.e. the health facility) of grid power, solar energy investments are cost-effective as back-up but not as a replacement to the power grid.

b. Water and sanitation for health services

Similarly, Nagaland requested technical support on water and sanitation in health facilities. Poor availability of clean water and poorly-maintained toilets are perceived as affecting service quality as well as the attractiveness of health services to the population, particularly women and girls. A field assessment of 33 health facilities found that only 4 had adequate running water for washbasins and only 3 had water connections for toilets. Most (27) facilities relied on water piped from streams, while 11 facilities experienced seasonal water shortages. Only a few facilities had water supply arrangements needed for good hygienic conditions for patients and staff (i.e. functional water connections to washbasins and toilets). Despite the apparent abundance of water, particularly during the monsoon season, the settlement pattern in the state, with villages perched on hilltops, constrains accessibility of water sources, so that most households are dependent on water piped varying distances from upland surface sources (i.e. streams and springs) fed by constrained rainfall catchment areas. With regard to sanitation, the assessment found that only a few facilities had toilets with running water connections; at the same time, although many toilets were clean and functional, a good number were poorly maintained or not in use. In all facilities, toilets are connected with buried septic tanks or pits, although
these are not emptied and there are no evident arrangements for waste treatment or filtering. Investment recommendations included repair and upgrading of piping and storage facilities linked to existing water supplies, as well as installation of roof-water harvesting systems (which may act as the main water source for small facilities such as Sub-Centers, and as back-up for larger facilities). Improvements to sanitation facilities would include upgrading septic tanks, including anaerobic filter installations, and putting in place the necessary plumbing connections to discharge wastewater from sinks, toilets and drains to the improved septic tanks.

c. Community management of health services

Nagaland’s population of about two million is mostly from tribal communities. Building on tribal governance structures, the state’s 2002 “Communitisation of Public Institutions and Services Act” transferred responsibility and resources for management of local services to community-level committees. The extent of decentralization of responsibilities and resources is somewhat unique in the Indian context. The state government requested the World Bank to support a situation analysis and development of a strategy to strengthen communitisation in the health sector. Fieldwork was conducted in four districts, and involved visiting and interviewing 19 committees. The team also consulted widely with stakeholders within and outside the state government. The assessment found that there are functional Health Committees at most health facilities that were visited. Most committee members were motivated. However, communitisation in health is far from achieving its potential, as committees are not always constituted according to the guidelines, especially with regard to involvement of women, and there is incomplete understanding of their role, as they are often focused on monitoring rather than managing. A strategy and plan were developed designed to empower Health Committees to oversee, manage and improve health services as well as undertake health and nutrition-related activities that are priorities for them. This included significant capacity building, encompassing support to committees in identifying existing gaps and priorities, determining the most suitable approaches to address these gaps, developing action plans and operationalizing those plans. A results-based incentive strategy was recommended whereby funding would be provided to communities on the basis of progress on defined indicators of improved health and nutrition-related services and practices. In turn, communities would use the incentives for activities and investments that are important to them and which have potential impacts on health and nutrition.

d. Human resources for health

Both Nagaland and Meghalaya requested technical support on human resources in the health sector, with a focus on retention and performance of government health staff in rural areas. In each state, over 50 key informants were interviewed, including: medical and nursing students; public-sector doctors, nurses and specialists practicing at district health facilities; private-sector doctors, specialists and nurses; and key informants from state and district health departments working on human resource matters or managing public health programs. The assessment found considerable intrinsic motivation to work in rural areas Meghalaya and Nagaland due to family and community ties. There were a
number people interviewed who were first in their family, community or tribe to enter a health profession. The assessment identified numerous challenges to working in rural areas, including difficult living and working conditions (including with regard to power supply, water and sanitation), poor service delivery conditions (including insufficient staff, poor equipment and drug supply), low salaries and incentives, and inadequate human resource management. Recommendations includes the areas of remuneration, human resource allocation and management, training, and working and living conditions. Meghalaya’s experience with mandatory rural service for health professionals was examined. On the basis of this work, the state governments will develop a medium-term health human resources development plan.

In addition, Nagaland requested World Bank technical support to planning for establishment of the first medical college in the state. Detailed plans and technical specifications in the areas of infrastructure, equipment, budgeting, human resource requirements, and other issues, were completed.

e. Supply chain management

Both states similarly requested support on improving procurement and supply chain management systems for government health services. Assessments included field visits to health facilities and warehouses and interviews with officials and health staff. An in-depth “mapping” of procurement and supply chain management processes was done including forecasting and planning, quality controls, distribution networks, vendor selection, and inventory management. The assessment found that systems are characterized by manual processes, lack of trained staff, poor storage infrastructure, insufficient procedures, and resultant irregular supply of medicines and consumables. Detailed blueprints improving these systems were developed, including institutional changes, development and adoption of standard operating procedures, training, information system, and infrastructure investment. Although a longer-term objective could be creation of autonomous centralized procurement entities (like the Tamil Nadu Medical Services Corporation), it was recommended that the two state governments start with rationalizing and clarifying responsibilities for procurement and supply chain management within a single unit in their Departments of Health & Family Welfare. Measures were recommended to improve planning and ordering, procurement, quality assurance, storage, inventory management, distribution and monitoring.

f. Information and communication technology (ICT)

The two states also requested technical support to assess and provide recommendations on the possible use of ICT to improve management and delivery of health services. This work drew on example from across the world on effective use of ICT in the health sector in low-resource settings. Lessons from India and elsewhere emphasize the importance of establishing a single inter-operable platform on which priority applications can be developed, avoiding discrete and uncoordinated investments. Needs and possible ICT strategies were identified in each state, including in the areas of: (a) supply chain management, including planning, ordering, monitoring and management of medicines,
consumables and equipment; (b) financial management, enabling faster approvals and improved budgetary processes and expenditure tracking; (c) human resource management, including career progression, posting and training management, as well as payroll and leave processing; (d) health management information system, including reducing the reporting burden on front-line health staff through the use of mobile applications for program data collection and beneficiary tracking; and (e) mobile applications to enhance the reach of health behavior change communication initiatives. In Meghalaya, this work focused on assessment and improvement of an ICT investment plan that had already been done and proposed for financing by a national e-governance program. In Nagaland, a comprehensive assessment and investment plan were produced, as well as draft terms of reference for the recommended “managed service provider,” to be contracted to manage and undertake the planned investments.

g. Health facility and household survey design and quality

Finally, the government of Nagaland requested support to design and quality assurance of health facility and household surveys that it is currently implementing. These surveys are designed to help address a large gap in knowledge about health services and household behaviors related in Nagaland, in order to inform policy and investment decisions. The Bank-supported technical assistance included: (i) design of the surveys, including a survey of primary health facilities, a hospital assessment, and a household survey; (ii) development and pre-testing of the various survey instruments; (iii) support to the Department Health & Family Welfare in hiring the necessary personnel and organizing data collection; (iv) training of survey personnel; (v) design and quality assurance of data entry; and (vi) quality assurance of data collection.

4. Results

Like in the rest of India, the National Health Mission has since 2005 provided a technical framework and significant resources for improving primary and first-referral health services in Meghalaya and Nagaland. This has included standard-setting and technical guidelines in many areas, such as population-based standards for infrastructure and human resources and the technical content of service to be delivered at different levels of the government health system. These states’ requests for technical support therefore focused on areas that have not been covered by the National Health Mission (i.e. energy and water and sanitation for health services, ICT, supply chain management) or where additional attention and support is needed (i.e. human resources for health).

This Bank-supported technical work is intended to lead to changes in policy and management, as well as inform future investments, thereby leveraging the effectiveness of central and state government spending on health services. In Nagaland, the work has had a clear impact, determining to a great extent the technical content of a proposed IDA-financed investment project (P149340), as well as laying the basis for further work and dialogue on medium-reform of difficult policy issues (particularly in the areas of health human resources and overall organization of health services in the state). This technical assistance has directly leveraged US$ 48 million in IDA financing and US$ 12 million in
state government financing for the proposed project, as well as US$ 10 million in central government funding to establish a medical college.

In Meghalaya, this work has provided a platform for dialogue on relevant policy and investments in the relevant areas. Unfortunately, the state’s e-governance proposal will not be funded by the central government, but the ICT investment plan is available to be funded from other sources. A possible proposal for an investment project is under discussion. This ongoing dialogue has also expanded to possibilities for strengthening cross-sectoral coordination at the community level, particularly between health, nutrition and early childhood education. As follow-up to this, as well as the community-level work in Nagaland, the team has proposed support from the SAFANSI trust fund for a continuing program of technical assistance, focusing on health-nutrition-early childhood education linkages at the community level.

This technical work can also be useful for other states as well as perhaps other countries. The World Bank, World Health Organization (WHO) and UNICEF recently published reports on both energy and water/sanitation for health facilities.¹ The assessments in Nagaland provide among the first empirical cases of work in this area, including not just broad program recommendations but also detailed technical specifications that should be useful in other contexts. Just as Meghalaya and Nagaland requested support in these and the other technical areas, other states should be able to learn from this technical work since it has not been covered by the National Health Mission or other sources of support. It is mainly for this reason that the team has produced knowledge briefs that can be provided to other state governments as well as be made freely available on the internet.
