PROJECT APPRAISAL DOCUMENT

ON A

PROPOSED CREDIT

IN THE AMOUNT OF
SDR 95.90 MILLION
(US$152 MILLION EQUIVALENT)

TO THE

REPUBLIC OF INDIA

FOR A

UTTAR PRADESH HEALTH SYSTEMS STRENGTHENING PROJECT

November 18, 2011

Human Development Department
South Asia Region

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CURRENCY EQUIVALENTS
(Exchange Rate Effective: 10/31/2011)

Currency Unit = Indian Rupees (INR)
US$1 = INR 48.76

FISCAL YEAR
April 1 – March 31

ABBREVIATIONS AND ACRONYMS

ANM  Auxiliary Nurse Midwife  JSY  Janani Suraksha Yojana
ASHA Accredited Social Health Worker  M&E  Monitoring and Evaluation
AWC  Aanganwadi Center  MDG  Millennium Development Goal
AWW  Aanganwadi Worker  MIS  Management Information Systems
CAG  Comptroller and Auditor General of India  NRHM  National Rural Health Mission
CAS  Country Strategy  PAD  Project Appraisal Document
CCT  Conditional Cash Transfers  PCB  Pollution Control Board
CMSD  Central Medical Stores Department  PCT  Project Coordination Team
CQI  Continuous Quality Improvement  PGB  Project Governing Board
CSS  Centrally Sponsored Scheme  PD  Project Director
DIID  Department for International Development  PHC  Primary Health Center
DLI  Disbursement Linked Indicator  PIP  Project Implementation Plan
DOHFW  Department of Health and Family Welfare  PIS  Personnel Information Systems
DP  Development Partner  PPP  Public Private Partnerships
DRC  Data Resource Center  PSC  Project Steering Committee
EP  Equity Plan  PSU  Project Support Unit
EDP  Electronic Data Processing  QA  Quality Assurance
EEP  Eligible Expenditure Program  OOP  Out of Pocket
EMPEP  Environment Management Plan  RSBY  Rashtriya Swasthya Bima Yojana
FMN  Financial Management Manual  SIL  Specific Investment Loan
FRU  First Referral Unit  TOR  Terms of Reference
GSMD  Gross State Domestic Product  UNICEF  United Nations Children’s Fund
GIS  Geographical Information Systems  UP  Uttar Pradesh
GOI  Government of India  UPHSSP  Uttar Pradesh Health Systems Strengthening Project
GOUP  Government of Uttar Pradesh  USAID  United States Agency for International Development
HKRC  Health and Knowledge Resource Centre  WHO  World Health Organization
IFRs  Interim Financial Reports

Regional Vice President: Isabel M. Guerrero
Country Director: N. Roberto Zagha
Sector Director: Michal Rutkowski
Sector Manager: Julie McLaughlin
Task Team Leader: Vikram Rajan
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Date: November 18, 2011
Country Director: N. Roberto Zagha
Sector Director: Michal Rutkowski
Sector Manager: Julie McLaughlin
Team Leader: Vikram Rajan
Project ID: P 100304
Lending Instrument: Specific Investment Loan

Sector(s): Health (100%)
Theme(s): Health system performance (100%)
EA Category: B

Project Financing Data
[ ] Loan  [X] Credit  [ ] Grant  [ ] Guarantee  [ ] Other:
Proposed terms: Standard IDA terms (i.e., 25 years maturity with 5 year grace period and 1.25% interest charge).

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Borrower:
Government of India, New Delhi, India

Responsible Agency:
Department of Medical Health and Family Welfare
Government of Uttar Pradesh (GOUP), India

Contact: Mr. M.P. Mishra
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Tel: +91-522-2310397
Email: pd_uphsdp@sify.com
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Project Implementation Period: January 15, 2012   End: March 31, 2017
Expected effectiveness date: January 15, 2012
Expected closing date: March 31, 2017

Does the project depart from the CAS in content or other significant respects? [ ] Yes [X] No
Does the project require any exceptions from Bank policies? [ ] Yes [X] No
Have these been approved by Bank management? [ ] Yes [X] No
Is approval for any policy exception sought from the Board? [ ] Yes [X] No
Does the project meet the Regional criteria for readiness for implementation? [X] Yes [ ] No

**Project Development Objective:**
The Project Development Objective is to improve the efficiency, quality and accountability of health services delivery in Uttar Pradesh by strengthening the State Health Department’s management and systems capacity.

**Project Description:**
The project would finance the following two components: (i) strengthening the Department of Health’s management and accountability systems; and (ii) improving the Department of Health’s capacity to perform its quality assurance role and more effectively engage the private sector. A summary of the two components is provided below and the components are fully described in Annex 2.

**Component 1: Strengthening the Department of Health's management and accountability systems (total estimated costs: US$55 million)** will support: (i) strengthening strategic planning functions in the Health Department, working closely with the recently established Health and Knowledge Resource Center (HKRC) in the Family Welfare Department; (ii) improving use of data for program management in collaboration with the existing Electronic Data Processing (EDP) Cell in the Department and expanding its scope to function as a Data Resource Center (DRC); (iii) strengthening the use of financial information for improved decision making through the existing accounting and auditing systems for treasury and society funds, and strengthening of procurement and supply chain management systems; and (iv) introducing and strengthening action research to introduce community assessment of health and health care at the local level and introducing provider incentives in the public sector. This Component would also support the services of a Procurement Agent (PA) and the Project Support Unit (PSU) which would support institutional capacity building and project implementation. The costs of the Technical Assistance Provider (TAP) will be shared by both components as technical assistance is required for implementation of both components.

**Component 2: Improving the Department of Health’s capacity to perform its quality assurance role and more effectively engage the private sector (total estimated costs: US$115 million)** will support: (i) strengthening the institutional capacity for service quality improvement and regulatory capacity, which would include establishment of, and capacity building for, the Quality Assurance (QA), Environment Management (EM) and Public Private Partnerships (PPP) Cells in the Directorate of Health; (ii) improvement of quality of service delivery at public sector hospitals to enable accreditation under the National Accreditation Board of Hospitals (NABH); (iii) contracting with the private sector for delivery of diagnostic
services and non-clinical support services; and (iv) and ensuring the availability of the full complement of human resources required for accreditation at each selected facility, and health managers at the facility level.

### Safeguard policies triggered?

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### Conditions and Legal Covenants:

#### Negotiations conditions:

- Completion of the Financial Management Manual for the project;
- Issuance of Request for Proposal (RFP) for the hiring of both a Procurement Agent and a Technical Assistance Provider

#### Board presentation:

To be scheduled on December 20, 2011

#### Board Condition:

None

#### Credit effectiveness:

None

#### Disbursement Condition:

None

#### Legal Covenants:

- Maintain, at all times during project implementation the quality assurance cell to be established under component 2 of the project, within Uttar Pradesh’s Directorate of Medical Health.
- Not later than six (6) months after the Effective Date, employ, and maintain throughout project implementation, as necessary, a Procurement Agent and a Technical Assistance Provider, under terms of reference and with qualifications and experience acceptable to the Association to assist the project Support Unit (PSU) to carry out its procurement obligations under the project and to provide the necessary consultancy support for project implementation, respectively.
- Not later than twelve months (12) after the Effective Date, employ, and maintain throughout project implementation an independent performance auditor, under terms of reference and with qualifications and experience acceptable to the Association, to carry out performance audits on an annual basis for purposes of DLI disbursement under the project.
I. Strategic Context

A. Country Context

1. Uttar Pradesh (UP) is India’s most populous state with an estimated population of nearly 200 million (17% of the population of India)\(^1\). Eighty-five percent of the population lives in rural areas and about 33%\(^2\) lives below the poverty line. The per-capita income of UP was US$522 relative to India’s average of about US$1,097 in 2010-11. UP has been ranked in the bottom third of the states on the Human Poverty Index since 1981, and the state lags behind all other states in the country on most human development indicators. The literacy rate is 70%, with 60% female literacy versus a national average of 74% and 65%, respectively\(^3\).

2. Uttar Pradesh will determine achievement of India’s own health goals and its health related Millennium Development Goals (MDGs), given the size of the state population and the disproportionately higher mortality and morbidity rates. Despite declines in maternal mortality, the state’s average remains the second highest in the country at 359 per 100,000 live births against a national average of 212\(^4\). Neonatal mortality (45 per 1,000 live births versus a national average of 35) and infant mortality (63 per 1000 live births versus a national average of 50 per 1000)\(^5\) are amongst the highest in the country. The total fertility rate of 3.8\(^6\) is the highest in India, although contraceptive coverage is increasing. Anemia (85% for children and 51% for women) and malnutrition are significant concerns with a high percentage of children underweight (42%), wasted (20%) and stunted (52%)\(^7\). Infectious diseases are still a major problem in UP, immunization rates remain very low (only 30% children are fully immunized by 12 months of age)\(^8\), and polio continues to be endemic in parts of western UP. Of the 264 “high focus districts”\(^9\) identified by the central Ministry of Health, 46\(^10\) are in UP. Although there are variations between districts and substantial inequities in both burden of disease and access to services across population groups, there is no individual region or district that is either succeeding or underachieving across all indicators\(^11\) which makes both explaining differences and targeting more challenging.

3. Public health spending has been steadily increasing in UP but overall per-capita spending on health is still low at about US$7.0 in 2008-09 versus a national average of US$8.0. The share of private health expenditure in total health expenditure was higher at about 87% compared to the national average of 80%\(^12\). Eight percent of households in the state fell below the poverty line due to health related out of pocket expenditures (versus a national average of 10.5%).

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\(^1\) 2010; Population projections for India and States: 2001-2026, Registrar General of India
\(^2\) 2004 based on a uniform recall period of 365 days; Poverty estimates for India 2004-05, Planning Commission
\(^3\) 2011; Census of India
\(^4\) 2007-09; Sample Registration System, Registrar General of India
\(^5\) 2009; Sample Registration System, Registrar General of India
\(^6\) 2008; Sample Registration System, Registrar General of India
\(^7\) 2006; National Family Health Survey - 3
\(^8\) 2007-08: District Level Household Survey - 3
\(^9\) High focus districts are districts with the worst health indicators and significant access issues that have been identified for priority action
\(^10\) Of a total of 71 districts in UP
\(^11\) For example, whereas eastern districts may be poorer, Polio is persisting in western UP
\(^12\) 2004-05, National Health Accounts of India, Department of Health and Family Welfare.
Total public health expenditure increased (in nominal terms) from US$0.74 billion in 2005-06 to about US$1.3 billion, with the share of state own health spending at about 80% of the total, and the balance financed through the federal government’s National Rural Health Mission (NRHM); in 2010-11, the total public health budget allocation was US$2.0 billion. As a share of its gross state domestic product (GSD), public health spending in UP at 1.6% is higher than the national average of about 1%. Within the state health budget of 2006-07, the share of primary, secondary and tertiary care was about 47%, 31%, and 22% respectively. With the additional resources from NRHM focused on primary care, the share of primary care is likely to be sustained, if not increased.

B. Sectoral and Institutional Context

4. Determinants of health for improved health status of a population lie both within and outside the health sector and hence multi-sectoral approaches to improve health outcomes are necessary. Effective delivery of sectoral services as well as intersectoral coordinated actions is a key to achieving health outcomes. A study for public services in UP identified that within each sector – health, nutrition, water and sanitation, rural development, urban development, and many others–some common underlying constraints such as weak institutions, accountability mechanisms, and poor organizational performance hamper service delivery and therefore affect achievement of desired outcomes across sectors. Thus, individual sectors, including health, would have to also address these systemic constraints while supporting the implementation of technical solutions that would help achieve outcomes. Access to and utilization of quality health care services in the state, both in the public and private sectors, will continue to be key determinants of improving the health status of the population of UP.

5. There has been some progress made in health service delivery the recent years. The conditional cash transfer scheme for poor pregnant women (Janani Suraksha Yojana or JSY) has increased demand for basic services across the country, including in UP. Institutional deliveries in the state have increased by 33% in the last 5 years. Coverage Evaluation Surveys by UNICEF in 2009 indicate that the institutional delivery rate in UP is now about 60%, and evidence improvements in ante-natal and immunization coverage. In the last five years, the percentage of 24/7 Primary Health Centers offering basic services has increased three fold (6% to 18%); most of these conducting more than 10 institutional deliveries per month. About 130,000 community health volunteers (Accredited Social Health Activists or ASHAs) have been recruited, trained and provided with basic kits to increase awareness and improve linkages with the community. There has been no reported case of polio in 2011.

6. Some improvements in health service delivery notwithstanding, key challenges remain. The percentage of 24/7 PHCs offering basic services is only 18% against a national average of 35.8%. Only 6% of First Referral Units (FRUs) offer comprehensive obstetric

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13 2004; National Sample Survey (NSS), 60th Round
14 US$ 1= INR 45
15 Chaudhuri 2007;The National Health Policy of 2002 sets the target share of primary, secondary and tertiary care in total public health investments to be 55%, 35% and 10% respectively.
16 Living Conditions and Human Development in Uttar Pradesh: a Regional Perspective
17 2005-2010: NRHM bulletin; according to District Level Household Surveys (DLHS), institutional deliveries have increased from 21% to 25% between 2003-04 to 2007-08
18 From Jan 1, 2011 to September 30, 2011, no cases of wild polio virus (WPV) induced polio
19 2007-08: DLHS 3 facility surveys
care\textsuperscript{21}, whereas the national average is 19%; and about 1\% only have blood storage facilities for life saving emergencies. Even where facilities for delivery care are available, the total complement of services are generally unavailable: all essential laboratory tests are available in less than 3\% of FRUs; thermal protection for babies in less than 10\% of facilities and a third of the women leave within five hours of delivering a baby\textsuperscript{22}.

7. **Health seeking\textsuperscript{23}** is among the lowest in the nation in rural UP at 7.7\% for acute illnesses (for India is 8.2\%), though reported illnesses are higher than the average for India. Positive health behavior such as initiating breastfeeding within the first hour of birth is the lowest in India at 15\% (compared to 41\% for India). While the ratio of private to public provision for out-patient treatment is 90:10, the type of private service provider is heterogeneous with a major share of “private providers” not fully qualified to provide medical care. Quality of care and clinical skills of service providers is variable across both the public and private sector as observed during national program reviews.

8. **Service delivery in other sectors that affect health has key challenges.** For example, sanitation in UP is very low and has not improved. Fifteen percent of rural households have access to a toilet whereas 65\% of urban households have access to a private latrine; the remainder of those without it poses a public health hazard. Less than a third of houses have electricity, although about 95\% of houses now have access to a drinking water source, a huge improvement in the recent years.\textsuperscript{24}

9. In order to provide health care to its population and thereby reach stated health goals, the **main investments by the health sector of the Government of Uttar Pradesh (GOUP)** have been to establish and operate an extensive network of public sector health facilities at the primary, secondary and tertiary levels. Most of the state government health financing is focused on inputs for public sector service delivery (infrastructure (20\%), supplies and human resource salaries (80\%). Through the **Government of India’s National Rural Health Mission (NRHM; 2005-2012)**, there is a focus on improving basic health services, mainly through investments in public sector infrastructure, contracting additional human resources and the provision of flexible financing to states. This financing is focused on providing incremental inputs to the service delivery level in the form of infrastructure (15\%), conditional cash transfers for pregnant women (15\%), grants to facilities and communities (15\%) and other additional operating costs (60\%). There are user fees levied at these facilities for various services and other expenditures which lead to out of pocket payments for both inpatient and outpatient services even in public sector facilities. An average hospitalization expenditure in rural UP in the public and private sector were INR 7,648 and INR 9,169 compared to the national figures of INR 3,238 and INR 7,408, respectively.

10. **Health financial protection in UP** is presently being addressed in the form of Conditional Cash Transfers (CCTs) to poor pregnant women (JSY), and a roll out of a federal health insurance scheme (Rashtriya Swasthya Bima Yojana – RSBY) by the federal Ministry of

\textsuperscript{20} FRUs are public sector facilities proving referral care for comprehensive emergency obstetric and neonatal care
\textsuperscript{21} Using the ability to provide caesarean sections as a proxy for comprehensive obstetric care
\textsuperscript{22} USAID 2008: Rapid Assessment of the Functionality of FRUs and 24x7 PHCs in Uttar Pradesh (for the Reproductive and Child Health II program)
\textsuperscript{23} 2004 NSS; as measured by accessing a health care facility for treatment during an episode of acute illness
\textsuperscript{24} DLHS 2 (2002-04) and DLHS 3 (2007-08)
Labor to provide health insurance coverage to all families below the poverty line, so that they can access empanelled public or private facilities up until secondary level of care. Recently, implementation of this scheme has been handed over to Department of Health and Family Welfare (DOHFW) from the Rural Development Department. Public expenditure on health insurance is still low at about US$60 million but reaches over 5 million households in the state and includes about 1600 hospitals in its network with a 40:60 public to private ratio. Explicit entitlements, effective delivery mechanisms, cashless access for beneficiaries, provider accountability and partnership with the private sector for provision of services are defining characteristics of a well performing health insurance system. The health department will itself need to build its capacity to deal with the changing paradigm in public financing of health services – as a purchaser, and to effectively engage with the insurance system as both a provider of services and as a regulator of the quality of care.

11. A Bank-financed project, the Uttar Pradesh Health Systems Development Project (UPHSDP; 2000-2008) supported investment in secondary health care services and systems strengthening. Complementary investments for primary and preventive health service were supported through Bank investments in national programs for reproductive and child health, immunization, polio eradication and disease control (TB, vector borne diseases, HIV/AIDS, cataract, leprosy). UP has also been the recipient of funding from several development partners (DP), including UNICEF, USAID, the Bill and Melinda Gates Foundation, WHO and several NGOs. Most DPs have also focused on improving service deliveries through direct point-of-service interventions, while only marginally addressing health systems and institutional issues affecting service provision.

12. Service delivery improvements depend on functioning health systems, including the availability of adequate and sustainable health financing and the ability of the health system organization to convert these resources into better health results for its population. While overall health financing is still low, it is not the binding constraint. Organizational performance of the public sector is key for improved allocative and technical efficiency of available financial resources resulting in improved health service delivery. Organizational performance is in turn determined by the institutional capacity and management systems, governance and accountability mechanisms, as well as its ability to effectively engage with the private sector.

13. The institutional capacity and management systems of the Health Department and Directorates are “the weak middle”. As the case in most other states in India, DOHFW and associated Directorates have mostly been organized for implementation of vertical disease-specific programs or for public sector clinical care delivery. However, key stewardship and public sector management functions required for a Directorate to manage programs that ensure delivery of accessible, affordable, equitable, efficient and quality health services are weak or virtually absent. These functions include strategic planning and comprehensive budgeting, monitoring and measuring performance, purchasing (such as through public private partnerships

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25 50% of the 10 million families that live below the poverty line.
26 USAID primarily supports family planning activities, providing and funds and implementing most of their activities through NGOs. UNICEF and WHO primarily support immunization, currently with special focus on polio eradication; UNICEF also supports child survival as well as water and sanitation related activities in a limited number of locations. The Gates Foundation has recently expanded its activities for maternal and child health in those districts with the poorest RCH indicators.
and outsourcing services), hospital management, federal health program management, health financing (including health insurance), human resource management, procurement and supply chain management and financial management. Public health and regulatory functions such as health prevention, disease surveillance, vector control, vital statistics, quality assurance of service delivery, food and drug regulation and healthcare waste management are also weak. There has been an attempt to build these capacities through parallel systems like program management units or vertical programs under NRHM, but capacities remain weak and the need to introduce these functions within DOHFW and the main Directorates remain.

14. **Weak governance and accountability mechanisms in UP represent major challenges to improved service delivery.** Decision-making is highly centralized in the state health authorities, and subject to political patronage which further impedes the already weak institutional mechanisms to deliver results. There also appears to be a gap between de jure and de facto rules applied to key managerial functions conducted at the state level such as human resource management. Accountability is diffused between elected officials and local administrators/providers, between elected officials and citizens, and between citizens and local administrators/providers. A 2008 study found that Panchayati Raj Institutions in UP have no formal role and little participation in health system functions, including review of state level decisions, planning, budgeting and management of local staff. Social audits are rare. The Village Health and Sanitation Committees, which are the major social accountability mechanisms under NRHM, have been formed in less than 30% of villages, and most of them are yet to be functional (Annual Report of NRHM, 2009). Absenteeism, high staff turnover, lack of appropriate training/skills, absence of citizen grievance redressal, and monitoring failures combine to undermine sector performance. Community driven accountability mechanisms for improved service delivery, and community led approaches to improving health promoting and health seeking behavior are also limited across the state.

15. **Systematic planning and investment in improving quality of service delivery and its supportive regulatory environment has been limited.** While considerable investment to upgrade health facilities is being provided under NRHM and through the state budget, the lack of adoption of a standard framework and procedures, rational planning of human resources (quantity and skill mix), the absence of facility based health managers, and Continuous Quality Improvement (CQI) programs, results in poor quality of services being produced from these investments. As described above, the full complement of services is not available at both PHCs and FRUs resulting in a relatively small proportion of them functioning as per defined norms. The recent introduction in the country of both the National Clinical Establishment Act and National Board of Accreditation of Hospitals (NABH), now provide a framework to develop a set of uniform standards that can be adopted to enable health facilities, both in the public and private sectors, to deliver quality health services. GOUP is also cognizant of, and is addressing the human resource gaps in the state. There is about one registered doctor (public or private) per 4,150 population compared to about 1:2,000 for India. The problem of lacking adequate number of human resources is consistent with the vacancies in sanctioned public sector posts (about 19% for doctors and 19% for nurses). Though available data is not very reliable, estimates of gaps in

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27 Bossert, Dayal, and Sharma (2008)
28 Panchayati Raj Institutions are locally elected bodies mandated for decentralized governance at the village, block and district levels under the Constitution of India
29 Social Audit is an assessment done by communities to provide feedback on effectiveness of service delivery
30 2009-10, Report on NRHM, Comptroller and Auditor General of India
the public sector for nurses using Government of India norms is close to 25,000 and overall sector shortages maybe even higher due to the low nurse densities. The state is utilizing the capacity available from the large number of private nursing schools in UP, but given quality concerns in these schools, there may be a need to focus not only on numerical adequacy but on aspects of production quality and management of nurses. While there is an overall shortage of human resources in the public sector, there is also need to improve allocation of these scarce human resources to improve service delivery. For example, the number of first referral units (FRUs) are not as high as the number of obstetricians, pediatricians and anesthetists already available in the public sector as they are not necessarily posted to the same facilities to enable emergency obstetric care. In addition to other human resource management challenges, one of the key bottlenecks in addressing this issue also a lack of systematic and dynamic information systems for better human resource and personnel management.

16. **Private sector partnerships in order to purchase services from the private sector have not been fully exploited.** While the state has been exploring and has piloted some Public Private Partnerships (PPPs) and outsourcing contracts, there is enormous potential (in areas of service delivery as well as human resource training and production) which has not been expanded due to low capacities in the Health Directorate to design and manage PPPs and outsourcing contracts. With over 60% of provision of inpatient care and over 90% of outpatient care being delivered through the private sector and investments required to enhance HR production, harnessing the technical, managerial and financial resources of the private sector may be key to expanding quality services. The quality of the private sector however is variable, and improved regulation by the state will be necessary to improve quality of private sector services.

17. Thus, despite government, donor and private investments in the health sector in Uttar Pradesh, the main challenges that are undermining the full impact of the inputs are centered on inadequate organizational performance.

C. **Higher Level Objectives to which the Project Contributes**

18. The proposed project is aligned to the goals outlined in the Five Year Plans for India and UP (2007-12) and in the National Rural Health Mission (NRHM – 2005-12). It would support Uttar Pradesh in improving systems towards achieving MDGs 1, 4, 5 and 6 (related to nutrition, reduction of child mortality, improving maternal health and controlling communicable diseases). UP is a low income state with some of the lowest health indicators in India, and is therefore a high focus state for the health sector. This project would support the state in building the necessary institutional capacity to help it achieve sustainable health outcomes.

19. The proposed project is well aligned with the 2009-2012 Bank’s Country Strategy (CAS, dated November 14, 2008) under its third pillar which aims to support improvements in the organization and delivery of publicly-financed services that would enhance the development effectiveness of public spending, including in the health sector. The emphasis of this pillar is on the following, which would all be addressed by this proposed project: (i) getting results (including demand-side accountability through beneficiary, civil society and community involvement); (ii) strengthening capacity for publicly-provided services; and (iii) enhancing private sector participation. A stronger focus on implementation, and monitoring and evaluation, as supported by the proposed project, is also a key feature of the CAS. The proposed project
represents the next step in an ongoing transition of the health portfolio and supports the CAS’ desired shift away from “service delivery infrastructure heavy” projects towards institutional development, strengthening local systems and accountability, generating demand side accountability, and introducing incentives for performance and piloting alternative delivery models, including outsourcing services to the private sector.

20. The CAS also recognizes that engaging in low-income states is important to help India achieve the MDGs. The Bank support in low-income states envisaged during the 2004 CAS period did not take place to the extent foreseen. The current CAS reaffirms the importance of this engagement, devotes more resources to engaging with low-income states, and stresses the importance of accepting a higher degree of risk in low-income states than in more advanced states.

II. Project Development Objectives

A. PDO

21. The Project Development Objective (PDO) is to improve the efficiency, quality and accountability of health services delivery in Uttar Pradesh by strengthening the State Health Department’s management and systems capacity.

1. Project Beneficiaries

22. The main project beneficiaries would be the poor and disadvantaged population of Uttar Pradesh who are intended beneficiaries of centrally sponsored health schemes (federal government’s vertical programs) and state health programs. These health programs are targeted for the poor, and are implemented by the DOHFW and the Directorates of Medical Health and Family Welfare. However, institutional constraints impede service delivery to the entire population, including the poor. With the focus of the project on organizational strengthening and improved accountability to enable better service delivery through the public and private sectors, the entire population of UP, and especially the poor, stands to benefit. Better data management, an important subcomponent of the project, would ensure availability of disaggregated data by wealth quintiles and disadvantaged groups to enable management attention. Additionally, the specific support that the project would provide to improve quality of service delivery at hospitals and expand provision of quality diagnostic services through the private sector would ensure improved access and quality of service delivery in these areas, which would include underserved areas and the poor. Finally, the project would provide direct support to communities by financing the testing and evaluation (and scaling up of success) of models for community participation and engagement in ensuring greater provider accountability and improving health seeking behavior.

2. PDO Level Results Indicators

23. The following key performance indicators will measure the achievement of project objectives (see Annex 1 for more detailed information):
1. Percentage of hospitals under the accreditation program that annually produce data and monitor: service productivity, efficiency, quality, patient satisfaction, and accountability (efficiency, quality and accountability)

2. Percentage of districts using the personnel information system for paying salaries of health workers (efficiency and accountability)

3. Percentage of districts with completed and published facility-based report cards detailing national health programs indicators and facility-level performance data (efficiency and accountability)

4. Percentage of Primary Health Centers participating in the social accountability pilots for which a service delivery assessment has been completed and at least one corrective action by government is verified by the community (accountability)

5. Number of facilities using performance based contracts\(^{31}\) for non clinical services (outsourcing to the private sector for housekeeping and laboratory services)(efficiency and quality)

6. Percentage of hospitals under the accreditation program that have been certified for: (i) entry level pre-accreditation; (ii) progressive level pre-accreditation accreditation; and (iii) final accreditation (quality)

24. In addition to the above PDO indicators, a set of “service delivery monitoring indicators” that track improvements in related service delivery results will be monitored to test the assumed relationship between improved institutional performance and service delivery improvement. The success of the project will be measured against the PDO indicators, as well as intermediate outcome indicators, as detailed in Annex 1 but not against the “service delivery monitoring indicators. This is further explained under section IV B: Results Monitoring and Evaluation below.

III. Project Description

A. Project Components

25. Since weak institutional capacities and systems have been recognized as the key challenges to improving access to quality of health care services delivery in UP, the proposed project departs from the traditional “incremental inputs for service delivery”. Instead it focuses on institutional development, strengthening local systems and accountability, generating demand side accountability, introducing incentives for performance, and piloting alternative delivery models, including outsourcing non-clinical services to the private sector. The project would consist of the following two components: (i) strengthening the Department of Health's management and accountability systems; and (ii) improving the Department of Health’s capacity to perform its quality assurance role and more effectively engage the private sector.

26. Each of the components would finance specific inputs for the implementation of agreed activities, and will also disburse funds against the attainment of specific results using Disbursement Linked Indicators (DLIs). The tying of disbursement of financing to indicators is expected to contribute to the implementation of the described project components by providing an incentive to achieve the agreed results. A summary of the two components is provided below

\(^{31}\) Performance based contract means that a portion of payments are linked to quantifiable performance indicators.
which describes the activities to be undertaken under these components, nature of the specific inputs to be funded under these components and the DLIs incentivizing achievement of related results of these components. The components are further detailed in Annex 2.

**Component 1: Strengthening the Department of Health's management and accountability systems** (total estimated costs US$55 million)

This component will support the following activities:

(i) Building strategic planning functions in the Health Department, working closely with the recently established Health and Knowledge Resource Center (HKRC) in the Family Welfare Department. This Center would undertake selected, need-based analytical work and action research to provide necessary evidence for policy decision making, and enable a more sector-wide approach to planning, budgeting and evaluation;

(ii) Improved use of data for program management in collaboration with the existing Electronic Data Processing (EDP) Cell in the Department and expanding its scope to function as a Data Resource Center (DRC). The Project would ensure that data collected at each level is utilized for improved management of health programs, improvement of service delivery quality and health outcomes, supporting the State’s desire to focus on equity and reducing disparities in access to health care. The project would also support strengthening of the Personnel Information System (PIS) as well as introduction of Geographical Information Systems (GIS) to map health facilities;

(iii) Strengthening the use of financial information for improved decision making through the existing accounting and financial reporting systems for treasury and society funds, enabling the State to move to a unified financial management information system; and strengthening of procurement and supply chain management systems; and

(iv) Introducing and strengthening social accountability action research to introduce community assessment of health and health care at the local level and use community audits of service delivery and assessment information to stimulate community action to demand better services, and enhance positive health behaviors; and introducing provider incentives to improve performance in the public sector.

27. This Component would also support the services of a Procurement Agent (PA) and the Project Support Unit (PSU) which would support institutional capacity building and project implementation. The costs of the Technical Assistance Provider will be shared by both components as technical assistance is required for implementation of both components.

28. The specific inputs to be financed under this component include: consultant services (conducting studies, providing technical assistance, procurement agent services and training), non-consulting services (GIS data), non-clinical equipment (Information Technology related hardware and networking equipment), hiring of non-governmental organizations to implement social accountability pilots, performance based awards to facilities (provider incentive pilots) and operating costs (workshops, contractual staff for cells and other operating costs of project).

29. The total number of DLIs for this component is 4. Each of these DLIs will disburse on achievement of the associated DLI targets for each fiscal year. The total number of such targets
for this component is 14 and will disburse a cumulative value of US$28 million over the project period. The DLIs under Component 1 are:

- DLI 1: Percentage of districts using the personnel information system for paying salaries of health workers (same as PDO indicator 2);
- DLI 2: Percentage of districts with completed and published facility-based report cards detailing national health programs indicators and facility-level performance data (same as PDO indicator 3);
- DLI 3: Percentage reduction in procurement cycle time;
- DLI 4: Percentage of Primary Health Centers participating in the social accountability pilots for which a service delivery assessment has been completed and at least one corrective action by government is verified by the community (same as PDO indicator 4).

Component 2: Improve the Department of Health’s capacity to perform its quality assurance role and more effectively engage the private sector (total estimated costs US$115 million)

30. This component will support the following activities:

(i) Strengthening the institutional capacity for ensuring service quality and regulation, which would include establishment and capacity building of the Quality Assurance (QA), Environment Management (EM) and Public Private Partnerships (PPP) Cells in the Directorate of Health. This would enable strengthening capacity of the DOHFW and Directorate to introduce systematic QA mechanisms and supporting the implementation of the recently introduced National Clinical Establishment Act (whereby the government would need to regulate the quality of the private sector as well); further strengthening of healthcare waste management; and designing, managing and monitoring performance based contracting and PPPs;

(ii) Improvement of quality of service delivery at public sector hospitals to enable them to be accredited under the National Accreditation Board of Hospitals (NABH) using an “accreditation challenge method”;

(iii) Contracting with private sector in order to improving quality and efficiency of service delivery, including diagnostic services and non-clinical support services; and

(iv) Ensuring availability of the full complement of human resources required for accreditation at each selected facility, and health managers at the facility level.

31. The specific inputs to be financed under this component include: consultant services (conducting studies, providing technical assistance, training, handholding of facilities to achieve accreditation, accreditation fee), non-consulting services (outsourcing of diagnostic and housekeeping services), clinical equipment (for hospitals undergoing accreditation) and operating costs (workshops, contractual staff for cells and facilities and other quarterly cost).

32. The total number of DLIs for this component is 3. Each of these DLIs will disburse on achievement of the associated DLI targets for each fiscal year. The total number of such targets

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32 Procurement cycle time: Time taken from the date of invitation of bids to the date of contract award will be taken as procurement cycle time for the purpose of this DLI
for this component is 11 and will disburse a cumulative value of US$22 million over the project period. The 3 DLIs are associated with Component 2:

- DLI 5: Percentage of hospitals under the accreditation program that annually produce data and monitor: service productivity, efficiency, quality, patient satisfaction, and accountability (same as PDO indicator 1);
- DLI 6: Number of facilities using performance based contracts for non clinical services (outsourcing to the private sector for housekeeping and laboratory services) (same as PDO indicator 5);
- DLI 7: Percentage of hospitals under the accreditation program that have been certified for pre-entry level accreditation (same as PDO indicator 6).

B. Project Financing

1. Lending Instrument

33. The financing instrument is a Specific Investment Loan (SIL) for a duration of five years. As mentioned above, in addition to specific investments, the project would also use a results-based financing mechanism (through DLIs). The project financing leverages the larger financial resources available to the sector through state budgets and federal programs by strengthening organizational performance to deliver better results. The proposed project supports strengthening of the Directorate of Health rather than creating parallel implementation mechanisms to enable sustainability of results.

34. Disbursement Linked Indicators (DLIs) is a results based financing mechanism that disburses against the achievement of agreed performance indicators. The project will employ DLIs as an incentive to achieve project results by disbursing a portion of the total project financing upon achievement of key results related to the implementation of the project components. Lessons from previous projects indicate that financing of inputs by themselves may not provide the necessary incentives to achieve results as many processes that supplement these inputs may lie outside the direct control of the project. As this project is focused on systems strengthening to enable the state to use their own resources better, the DLIs provide the incentive for GOUP to use project inputs to achieve project results. There is strong linkage between the DLIs and the Project Development Objective (PDO) as well as the related PDO indicators. Six of the seven DLI indicators are same as the PDO indicators, emphasizing a strong link with achievement of project results and the DLIs. A brief description of the implementation of DLIs is explained in section VI C: Financial Management.

Project Cost and Financing

<table>
<thead>
<tr>
<th>Project Costs by Component</th>
<th>Total US$ million</th>
<th>Bank US$ million</th>
<th>GOUP US$ million</th>
</tr>
</thead>
<tbody>
<tr>
<td>Component 1: Strengthening the Department of Health's management and accountability systems</td>
<td>55</td>
<td>51</td>
<td>4</td>
</tr>
<tr>
<td>Component 2: Improving the Department of Health’s capacity to perform its quality assurance role and more effectively engage the private sector</td>
<td>115</td>
<td>101</td>
<td>14</td>
</tr>
<tr>
<td>Total</td>
<td>170</td>
<td>152</td>
<td>18</td>
</tr>
</tbody>
</table>
35. The proposed project will be implemented over five years, with an estimated total cost of US$170 million. This would be financed by an IDA Credit of US$152 million equivalent, as well as GOUP co-financing of US$18 million equivalent. The Bank financed portion includes funding under the DLIs of US$50 million with US$28 million for Component 1 and US$22 million for Component 2. The project would finance works, goods, consultant services, non-consulting services, training, incremental operating costs, and DLIs.

36. **Retroactive financing** will be permitted under the following conditions: (a) the activities financed are included in the project description; (b) the payments are for items procured in accordance with applicable Bank procurement procedures; (c) such payments do not exceed 20 percent of the loan amount; and (d) the payments were made by the Borrower not more than 12 months before the expected date of Financing Agreement signing. Given the project preparation schedule, the estimated date after which retroactive expenditures will be financed, is April 1, 2011.

C. **Lessons Learned and Reflected in the Project Design**

37. Uttar Pradesh Health Systems Development Project (UPHSDP, 2000-08): The first five years of UPHSDP, which was the Bank’s first state level engagement in the health sector in UP, focused primarily on strengthening public sector service delivery at secondary health care facilities, equipment maintenance for project supported facilities and training of service providers in 28 districts. Subsequently, during its three year extension phase, the project focused on systems strengthening, outreach services for inaccessible areas, and strengthening of district planning and management capacity. During this period, a system for health care waste management was introduced, outreach service delivery in inaccessible areas through partnerships with non-governmental organizations (NGO) was piloted, and one public hospital was supported for accreditation.

38. Drawing on the experience gained from the implementation of the first project, as well as the findings from over a decade of Bank financed state-level health lending operations in about ten states of India, the following key lessons are reflected in the project design:

- A parallel entity for project implementation undermines the institutionalization and sustainability of knowledge and capacity following project closure. Hence, management capacity building and systems strengthening needs to be done in the directorates of health, which are the main implementation entities;
- The focus of Bank financing needs to shift from mainly facility level infrastructure improvement to building systems and creating an enabling institutional environment for better service delivery;
- Developing systems to ensure quality service provision to the poorest requires investments in strategic planning, human resources and technical capacity in the state health directorates, and a long term engagement;
- The lack of skilled human resources is a key impediment to service delivery (in the public and private sector alike);
- Given the expansion of government funding for health under the NRHM, any project support needs to be aligned to the overall sector strategy and complement other financing in the state, including from other development partners; and,
• Alternate lending approaches, such as use of results-based financing, may be good complementary instruments to address long term policy and institutional changes.

IV. Implementation

A. Institutional and Implementation Arrangements

39. A Project Governing Board (PGB) has been established under the Chairmanship of the Chief Secretary, Government of Uttar Pradesh to provide overall direction, approval of posts and financial and legal sanctions for the project. The PGB will delegate powers to the Project Steering Committee (PSC) and Project Director (PD) in the interest of efficiency in the execution of project activities. The PSC under the Chairmanship of the Principal Secretary, Department of Health and Family Welfare, will consider proposals placed before it by the PD. The PD will have delegated financial and procurement authority from the PGB for project related procurement as well as organizing selection committees to select staff for project posts.

40. There will be a three tier structure (see Annex 3) for the day to day implementation of this project consisting of, (i) the Project Co-ordination Team (PCT) headed by the Project Director (PD); (ii) specialist support cells located within the Directorate of Medical Health; and (iii) a Project Support Unit (PSU) which will provide dedicated support to the PCT, the specialist support cells and other technical assistance needs of the Directorate and the Department.

41. The PCT will be responsible for overseeing the timely and effective implementation of the project. It will be led by the PD, who will be supported by an Additional Project Director (APD), who will be responsible for the overall day to day activities and supervision of the project. It will include other high level representatives from the Directorate in project related technical areas.

42. Specialist support cells located within the Directorate of Medical Health will support institutional strengthening, and will be responsible for implementing and managing activities supported under the project, related to their respective areas. The Project Support Unit (PSU) supported by the TAP, will be used to build institutional capacity within the Directorate of Health to enable it to implement various project activities (see figure 1 in Annex 3: Implementation Arrangements).

43. The Project Support Unit (PSU) will consist of staff specialized in areas relevant to the core needs of the project. The structure and specialists will reflect the need to support the specialist cells, implement innovative pilots and manage the fiduciary requirements of the project. A procurement agent (PA) will be contracted to carry out the procurement of goods, works and non-consulting services for the project. A Technical Assistance Provider (TAP) will provide TA consultancy support, as well as contract and manage external TA as required. Both the PA and the TAP will be supervised by the PSU under the oversight of the PCT.

B. Results Monitoring and Evaluation

44. The results framework, and monitoring and evaluation (M&E) plans for the project have been based on the following aims: (i) strengthening the state government capacity to generate, analyze and use data for informed decision making; (ii) focusing on measurement of
improvement in organizational performance results rather than service delivery or health outcomes in line with the project design; (iii) using state systems with data validation mechanisms to report on progress; and, (iv) evaluating outcomes and process of innovative activities and pilots to inform scale up (see Annex 1 for further details).

45. The results of the project would measure improvement in the health systems which are required to produce sustained changes in service delivery or health outcomes. The project design assumes that improved institutional performance will enable service delivery improvement by increasing the efficiency and effectiveness of the public health funding available. Measuring results under this project has three key challenges. First, one needs to test the assumed relationship effects to ensure that the strengthened institutional performance is indeed resulting in improved service delivery performance. Second, one needs to design the PDO indicators to measure what the project can be held accountable for (in this case institutional performance results) and not measure ambitious results at a level where project interventions do not have direct impact. Third, measurement systems for results are weak or absent and hence these systems need to be established before service delivery results can be measured accurately.

46. To address the above issues, the results framework has been designed to measure a core set of PDO indicators at the intermediate institutional performance level for which the project will be accountable for. In addition, a set of “service delivery monitoring indicators” that track improvements in related service delivery results will be monitored to test the assumed relationship between improved institutional performance and service delivery improvement. (please refer to Figure 1 below). These service delivery results will measure production, efficiency, quality, patient satisfaction, and accountability and are outlined in Annex 1. In addition, key milestones towards improving systems performance are used as intermediate indicators to benchmark progress. Disbursement Linked Indicators (DLIs) are also part of the results chain which is a mechanism to disburse against the achievement of agreed performance indicators and incentivizes achievement of PDO indicators. The model by which the project design is essential to affect results is described in Figure 1 below.

47. The focus of the investments in M&E under the project would be on strengthening the monitoring and evaluation systems of the state’s health department instead of creating parallel systems for reporting data for project purposes. Most information would be collected through the Health Directorate’s Information systems and the remaining information will be collected either directly by the PCT or in coordination with the Department or the Directorate. Validation of data using data triangulation or by a third party source would be used. Verification of the DLI results would be done using third party validation. Data would be collected through routine MIS, provider surveys, patient satisfaction and feedback surveys, facility based quality assessments, evaluations and community monitoring. Pilots and innovations will have appropriate evaluation designs to measure outcomes (against the counterfactual wherever possible), as well as document processes.

48. The PCT will be responsible for coordinating with the various directorates collecting this information and for conducting necessary surveys and evaluations using appropriately qualified agencies. The TAP would be tasked with these surveys and evaluation, in areas where they are not directly involved in pilots and interventions. Alternatively, the TAP may sub-contract firms to carry out validation of results and evaluations.
C. Sustainability

49. **Sustained Political Commitment**: The current State Government (a majority government elected for five years in May 2007) has shown its commitment to improving health care services in the state by increasing budget allocations for health. The state’s 11th five-year plan also places health as one of the priority sectors for the state government. In addition, the Central Government’s health priorities defined in the NRHM aim to meet the MDGs and to focus on high priority states such as UP in particular because it is the most populous state with health indicators that are among the lowest in the country.

50. **Institutional and Financial Sustainability**: The use of treasury system for FM arrangements of the project ensures that the project is mainstreamed financially and operationally within the states institutions and systems. Once stakeholders see improved results from the institutional capacity building within the DOHFW and its Directorates during the project period, it is envisaged that further mainstreaming would take place through internal demand for improved management, information and services. The project design is not focused on providing incremental service delivery inputs that need to be sustained post-project closure but instead focuses on increasing efficiency of current expenditures in health through state and federal financing. Strengthened organizational performance, which is the key objective of the project, would enable improved and sustainable financial management, procurement, data management,
continuous quality improvement initiatives, and community accountability systems; which in turn would lead to improved access to and quality of service delivery. By leveraging the financial and technical resources of the private sector as well, this project would help sustainable financing of specific clinical services that are provided in a limited way through the public sector.

V. **Key Risks and Mitigation Measures**

51. An Operational Risk Assessment Framework (ORAF) is attached in *Annex 4* which details the key risks (including associated fraud and corruption risks) and mitigation measures. The overall risk for project implementation is considered to be *Substantial*. This rating reflects the following key risks of the operating environment as well as the project design in the operating environment: (i) leadership risks (changes of personnel at both Principal Secretary Health and Project Director levels, which occur regularly in UP); (ii) technical capacity risks (lack of specialist personnel to support sector reform and the timely implementation of project components); and (iii) weak public sector management systems (planning, information, environment, monitoring, procurement, contract management and financial management).

52. The Governance and Accountability Action Plan (GAAP) is attached in *Annex 7* which details key actions and mitigating measures to be taken under the project, to address risks and strengthen management systems. The proposed project design exclusively focuses on the provision of intensive technical assistance for strengthening institutional capacity, which would address some of the weaknesses in the health systems in UP. Therefore, achieving key steps in the project implementation process itself is indeed contributing to mitigating potential risks identified herewith. Therefore, the key mitigations listed here are part of the project interventions: (i) the use of a three tier implementation structure (Project Coordination Team, specialist support cells in the Directorate and the Project Support Unit) to ensure the continuity of institutional memory and mitigate the effect of staff transfers; (ii) the contracting of a technical assistance provider (TAP) to provide technical assistance support to the project; (iii) improving management systems through the establishment of specialist cells in the directorate, the provision of a TAP and the project support unit; (iv) use of treasury systems, standard financial accounting software, limited accounting locations, documented accounting policies, internal audit and the Comptroller and Auditor General (CAG) use of an independent Chartered Accountant to audit project financial statements; (v) appropriate financial delegations, use of a procurement agent and TAP provider, procurement capacity building in Directorate, no decentralized procurement until capacity is built along with appropriate monitoring, procurement audits, disclosure of procurement information and the establishment of an effective complaints handling system; (vi) strengthening the department’s capacity to comply with the Right to Information (RTI) Act; (vii) publishing key facility based and national health program information through the department’s website; (viii) development of a grievance redressal system for the project, as well as in facilities enrolled for the accreditation program; (ix) use of citizen charter’s at facilities enrolled for accreditation; (x) strengthening of the internal vigilance function of the health department; (xi) use of social accountability mechanisms to improve provider responsiveness and (xii) addressing risks related to contract management by using third party and civil society oversight mechanisms. The project design through its focus on institutional development, strengthening local systems and accountability, provides an enabling environment for these mitigation measures.
VI. Appraisal Summary

A. Economic and Financial Analysis

53. Starting from a low base, UP has been able to make quick initial gains in key health indicators by an increase in public health spending by approximately 25% per annum in real terms from 2005-06 to 2009-10. However, further gains in health indicators are difficult to achieve in the presence of bottlenecks of key complementary inputs and weak public sector management functions that cannot be addressed by funding alone. An external stimulus along with the necessary technical guidance is needed to address the binding constraints facing the health sector in UP. The project is designed to address these constraints (please refer Annex 2 for details on project components). Although the financial envelope that the proposed project would bring (average of US$34 million per annum for 5 years) is quite small (only 1.7% only of the overall annual health budget of US$2 billion), it has a disproportionate value in improving the efficiency and effectiveness of the overall public health spending. The rest of this section summarizes the arguments in support of the preceding statement.

54. Key project interventions supporting the establishment of a strategic planning and policy unit that would generate evidence necessary for guiding public policy and investments in the health sector. The need for such a unit has never been as compelling as it is now when the health sector is getting increased government attention and resources. Building government capacity in stewardship and in planning/prioritization – the role that is so very central to government-will have a critical impact given when the state has not paid much attention to these functions in the past.\footnote{As per NSSO 60\textsuperscript{th} round, for every thousand population the state 13 in rural areas and 20 in urban areas got hospitalized in 2005 while the same for the nation as a whole was 23 and 31 respectively. With the urbanization rate of 21\% in the state and 28\% for India as per census 2001, the hospitalization rate comes to around 1.5\% in UP and 2.5\% in India.} Even if a third of the project’s annual financial assistance of US$34 million (project provides US$170 million for 5 years) is invested in stewardship and strategic planning interventions, this investment (of about US$11 million) would be justified to improve the impact of the state’s annual health budget of US$2 billion. Indubitably, this is one of the best buys in the health sector in UP.

55. The proposed project also includes interventions to improve the quality of care in public sector health facilities through accreditation. UP has been the first Indian state to have experimented with accreditation of public sector health facilities. In 2008, with the Ram Manohar Lohia (RML) Hospital in the capital city of UP. A rapid review of its performance pre- and post-accreditation highlights significant efficiency gains and quality improvements that can be attributed in a large measure to the accreditation process. For example, the average number of OPD cases per doctor increased by 14\% between 2007 and 2009 indicating significant efficiency gains. Similarly, the share of medication errors declined from 4.8\% in 2007 to 2\% in 2009, indicating quality improvements (please refer Annex 8 for fuller exposition of this analysis). The limited experience of other states, notably Gujarat, with the accreditation process too suggests significant improvements. The project will support accreditation of 40 facilities in different regions in the state. GOUP estimates that the cost of accrediting 40 facilities (US$0.78 million per facility) would be US$31.2 million; part of which (particularly the civil works) will be financed by the government from domestic sources. Assuming the accreditation of 40 facilities to be spread over 3 years, the annual cost of US$10.4 million would constitute only a small part
(0.53%) of the annual health budget of US$2 billion. With the limited financial envelop committed to this project intervention, the potential “returns” by way of improving health service delivery in public hospitals are substantial. The accreditation of health facilities should also benefit the poor as the quality improvements that come with accreditation require defining standard operating procedures right from the entry of patients in the hospital through discharge/referral and follow-up, ensuring that the quality of care remains the same irrespective of the socio-economic background of patients.

56. Another intervention planned under the project deals with contracting of laboratory facilities in public hospitals where such services are known to be either non-existent or poor. Diagnostics, which include laboratory services, account for 14% and 15.4% of out-of-pocket (OOP) expenditure in public facilities in rural and urban areas of UP respectively34 (NHA 2004-05). Lack of availability of and accessibility to laboratory services may be one of the reasons behind substantially low hospitalization rates observed in UP in comparison to national average. For every 1000 population only 15 persons got hospitalized cases in UP as compared to the national average of 25. The project plans to support outsourcing of laboratory services in all the 40 facilities that will be accredited under the project. Outsourcing of laboratory services may be strengthened more widely to other facilities in different districts too. These services will be available free of cost to the poor while the non-poor will benefit from discounted prices (significantly lower than the market rates owing to provision of volume guarantee) that government would negotiate with the contracted agencies. The experience of the RML hospital indicates that the BPL patients do constitute a substantial portion of the beneficiaries of these services.

57. Given the institutional and systems strengthening focus of the project, and the importance of building capacity in stewardship, strategic planning and prioritization for the health sector, there is strong justification of the project design from an economic standpoint. The interventions envisaged in the project, if accomplished, will have a lasting impact in improving allocative and technical efficiencies of resources deployed in the health sector in UP. Given the small size of project investments (1.7% of public health budget per annum), sustaining project activities financially beyond the life of the project should be possible, especially at a time when health sector is attracting increasing government attention and resources.

B. Technical

58. The technical design of the project is appropriate to the client’s needs and based on the key reform priorities of GOUP. Section IA and B (country and sectoral context) outline the progress and challenges on key health indicators, the health financing scenario as well as the key systemic challenges. Despite government, donor and private investments in the health sector in UP, the main challenges that are undermining the full impact of these inputs, are centered on weak organizational performance (i.e., how resources can be better utilized to attain results). This in turn is due to the poor governance environment, weak institutional systems and management capacity.

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34 2004-05: National Health Accounts
59. The proposed project, therefore, will focus on strengthening the State Health Department’s systems and management capacity to enable more effective use of the much larger (and expanding) pool of state and Government of India health funding to improve health service delivery. This would be done by strengthening information systems for data based decision making and performance monitoring, strengthening fiduciary systems, making providers responsive to communities through social accountability and improving regulatory capacity for quality of service delivery. The relationship between the inputs available, the management and system improvements of health institutions supported by the proposed project and the improvements in health service delivery for the state is shown in *Figure 1: Illustrative Results Chain in Section IV B. Results Monitoring and Evaluation.*

60. The technical strategies under the project are focused on improving key technical areas of the institutional environment, which result in improved institutional performance in these areas and thereby leading to better service delivery. For example, to improve quality of care in hospitals, there are a number of project interventions that lead to improved institutional performance, which results in better quality of care in service delivery over a period of time. This includes improving the capacity of the state to regulate and support quality assurance (QA cell), strengthening the information and monitoring environment (Data Resource Centre), supporting the accreditation process under the NABH and supporting the processes to ensure availability of human resources in these facilities through improved Personnel Information Systems and contracting additional human resources. This ensures that available financing and resources from state and federal budgets are used more efficiently for improving quality of care in service delivery rather than just providing incremental and often unsustainable inputs for service delivery. This linkage between project interventions focused on improving the institutional environment and ensuring better service delivery over a period of time is applicable to other project interventions as well. This shift away from just transaction intensive investments in goods and works and towards assisting states in developing rigorous systems and sound accountabilities to enable more effective use of the much larger (and expanding) pool of state and GOI health funding is in line with the technical strategy for the India health sector.

C. Financial Management

61. The Project will be implemented by the DOHFW and will, to a large extent, use the existing financial management (FM) systems of GOUP. Financing of project activities will mainly be managed by the PSU with implementation of specific activities by approximately forty hospitals. The financial management (FM) arrangements of the project are based on use of the FM country systems with the additional features of separate financial reporting and internal audit arrangements for additional fiduciary assurance. Overall these arrangements are considered adequate to meet the Bank’s requirements as described below.

62. The State Government will make an annual allocation for the project as part of the budget of the Health Department under a separate head titled ‘Externally Aided Projects’. The budget will be approved by the Legislature, further for the DLIs the Bank will finance a share of the salaries/allowances paid to Health Department staff.

63. Accounting will be done on a cash basis, using government systems; expenditure will be recorded and reported at time of final payment for goods, services and other expenditures. Rules for accounting will be guided by the State Financial Handbook and Budget Manual as applicable.
to all transactions in UP. Adequate records will be maintained at accounting locations and will include vouchers, invoices, cash books, ledgers and asset registers. The project FM arrangements are documented in form of a Financial Management Manual (FMM) which refer to the relevant state rules and provide guidance on budgeting, funds authorization, accounting, internal controls, reporting and audit arrangements.

64. The Finance Function in the Department is headed by a Finance Controller who will provide overall supervision. At the PSU, the FM function will be discharged by an Officer from the Finance Department in full time capacity who will be supported by an experienced Consultant and adequate number of support staff (accountants). At the hospitals, the FM function will be discharged by the existing accounting staff.

65. Funds flow will be from the Bank to the GOI and on to the GOUP; the state government will allocate funds to the Project accounting locations using the Treasury Systems. The Project would submit semi-annual Interim Financial Reports (IFRs) duly reconciled with Treasury reports. The IFRs would report on activities, expenditure made in the previous six months and forecast for the next six months. The Bank will disburse funds based on the IFRs by following two different mechanisms; firstly, semi-annual disbursements based on inputs where expenditure will be reimbursed at 85%; and, secondly, annual disbursements on achievement of certain indicators (DLIs) as explained subsequently.

66. A brief description of the implementation of DLIs is as follows. The disbursement against DLIs would be on achievement of agreed indicators and targets (refer to Annex I). The validation of results would be done by a third party. There will be four rounds of annual disbursement in 2013, 2014, 2015 and 2016. There are 7 DLIs with 25 associated DLI targets over the project period. Each DLI target will have a value of US$2 million totaling to US$50 million over the project period. Each DLI is independent of the other, i.e., non-achievement of some DLI targets for a year will not hold up disbursement against other DLI targets that have been achieved for that year. The DLIs would be “floating” where non-achievement of a DLI target can be carried over to the next year to a maximum of one year. Bank guidelines on Investment Lending require that disbursement take place against an activity that is eligible for Bank financing. Therefore, the Eligible Expenditure Program (EEP) that will be considered for this purpose is salaries/allowances paid to health sector staff and confirmation of expenditures will be obtained through audited financial statements; Copies of the State Finance Accounts/Appropriation Accounts issued by the Comptroller and Auditor General (CAG) of India will confirm the salary payments. Disbursement against DLIs will take place after confirmation of eligible expenditures through audit reports and validation of the agreed DLI targets to be achieved, and will be repeated every year for a total of 4 years.

67. The Internal Audit function under the project will be entrusted to a firm of Chartered Accountants. The qualifications of the firm and Terms of Reference for audit will be subject to a review by the Bank. The audit will be on a periodic basis and would review transactions on a reasonable sample basis, results of this audit would form the basis for management action.

35 Expenditure recorded on the EEP for FY 2009-10 was INR 23708.20 million
36 Salaries and dearness allowance paid under Grant Nos. 32 (Medical – Allopathy) and 35 (Family Welfare)
68. The Comptroller and Auditor General (CAG) of India through its office in UP will be the statutory auditor for the project. The CAG will conduct an annual audit of the Project as per a Terms of Reference that has been agreed with the CAG for all Bank Projects in India; the audit report will be submitted to the Bank within six months of the close of each financial year. The report would also be displayed on the GOUP/Project website.

D. Procurement

69. This project will involve the contracting of services, some medical and other equipment and minor civil works as required. Due to weaker procurement capacity of the implementing agencies, a professional procurement agent (PA) will be hired to handle the procurement of goods, works and non-consulting services. The procurement agent will also be responsible for skill transfers to Central Medical Stores Department (CMSD) as well as procurement capacity building in CMSD and at the decentralized level. The procurement agent will report to a senior functionary (APD or Joint Director, Procurement) and will work closely with procurement experts of the Project Support Unit (PSU). A Technical Assistance Provider (TAP) as a consortium/firm will be selected to provide (or assisting the PSU in procuring) various consultancy services planned under the Project. PA and TAP will also help the Project in contract management. Public Private Partnership (PPP) may be used for implementing some of the sub-components of the Project only to the extent of outsourcing contracts. No decentralized procurement is envisaged under the Project until procurement capacity is strengthened to the satisfaction of the Bank.

70. The day-to-day procurement functions (procurement planning and monitoring, coordination with procurement agent/TAP and technical cells, reporting and coordination with the Bank, implementation of procurement risk mitigation plan/GAAP) under the project will be looked after by two procurement experts already in place (one in-charge of goods/works and another for consultancy/non-consultancy services) who are part of the Project Support Unit (PSU). These procurement experts will report to the APD or Joint Director (Procurement) who will be deputed from the CMSD. The Remote Sensing Applications Centre (RSAC) under the Department of Science & Technology, Government of U.P along with assistance from the National Remote Sensing Centre (NRSC) of the Indian Space Research Organization, Department of Space, Government of India, will assist implementation of HGIS as a Force Account unit.

71. The project will assist the Government in strengthening and improving the procurement and supply chain management systems in the CMSD to ensure timely availability of quality drugs, equipment, and supplies in order to deliver quality health services in the State. This will also include moving to an e-procurement system.

E. Social (including safeguards)

72. The overall goals of the GOUP’s health programs and centrally sponsored schemes are to ensure access of the poor and vulnerable groups to services. However, the weak institutional structures affect overall service delivery, including the equity focus of these programs. The project’s focus on institutional strengthening to improve service delivery would therefore also strengthen the equity focus. The Data Resource Center (DRC) and Health Knowledge Resource Center (HKRC) that would be strengthened under the project would develop mechanisms for
collection and analysis of disaggregated data for decision-making and design of appropriate strategies and plans to ensure that services reach the poor. They would also assess whether health outcomes improve and disparities decline. Social accountability mechanisms would be developed as potentially effective ways to improve health care at the local level, including household health behavior. Together these activities could make significant changes in UP’s health system and positive impacts on its health indicators.

73. The key risks to achieving the pro-poor focus and instruments are: the vast quantum of resources – human, material and financial – needed to both develop and deliver services to the large population and area of the state and the tendency for resources to be captured by elites; and the low demand for services by poor communities. The project seeks to address issues of differential access to benefits, competition for scarce resources, inadequate targeting and delivery mechanisms, and ‘low’ voice and governance through its systems strengthening and social accountability activities.

74. Primary and secondary stakeholders of this project, including poor communities, health providers and civil society organizations, were consulted during the Social Assessment, and they will be participants in the social accountability mechanisms to be designed and piloted during the project. Specific activities in institutional strengthening that would contribute more directly to strengthening the equity focus in service delivery are identified in the Equity Plan in Annex 3.

F. Environment (including safeguards)

75. This is rated as a category “B” project. One of the key achievements of the first Bank supported health sector project in UP (UPHSDP) was the introduction of systematic arrangement for biomedical waste management; including contracting CTFs on a turnkey basis. Implementation on the ground was found to be mixed and a key lesson learnt from the earlier project was that requisite systems and an enabling multi-sector institutional environment needed to be put in place for improved and sustained monitoring and implementation of this cross-cutting component.

76. UPHSSP will therefore initially support the establishment of an institutional structure – an Environment Management Cell (EMC) – which will be responsible for coordination of the environment related activities of DOHFW across the state. The EMC will be established within the Directorate of Medical Health by issuance of a Government Order and for effective functioning and sustainability, funding of the EMC will be from the state budget resources and NRHM. The EMC will report to the Secretary and the Project Director (during project lifetime) and will comprise officials from the DOHFW and related directorates, and deputed officials from other relevant departments (such as the UP Pollution Control Board).

77. Based on a needs assessment, the EMC will develop a road map for proper implementation, monitoring and reporting of biomedical waste management and infection control activities and other environment related issues as per the regulations of Government of India and guidelines of the Central Pollution Control Board. An evaluation at mid-term and at the end of year 4 will be undertaken to assess effectiveness of the EMC and the appropriateness of

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37 Common Treatment Facilities: CTFs are facilities mandated to dispose off-natural waste in compliance with the nation bio medical waste management rules and are regulated by the State Pollution Control Board.
the Roadmap. Findings and recommendations will be built into a revised Roadmap for subsequent roll-out across the state. Given the challenging task of setting up this inter-sectoral institutional mechanism, the establishment of the EMC will be undertaken over the first two years of the project lifetime. The proposed activities and how the project intends to take this forward has been defined in an Environment Management Plan (EMP), which has been approved by the GOUP and the Bank, and disclosed as per Bank’s Disclosure Requirements.
Annex 1: Results Framework and Monitoring

INDIA: UTTAR PRADESH HEALTH SYSTEMS STRENGTHENING PROJECT

1. The results framework, and monitoring and evaluation approaches for the project have been based on the following principles:

- Since this project is focused on strengthening organizational performance rather than provide incremental inputs for service delivery, the results of the project would measure improvement in organizational performance results rather than service delivery or health outcomes
- There is no recognized composite indicator to measure improvement in organizational performance results and hence key “marker” indicators are used
- The focus of the investments under the project will be on strengthening the monitoring and evaluation systems of the state’s health sector instead of creating parallel systems for reporting data for project purposes
- Most information will be collected through the state’s system while the remaining information will be collected either directly by the PCT in coordination with the Department or the Directorate;
- Validation of data from using data triangulation or by a third party source will be used wherever quality of existing reporting is poor not thought to be robust or valid
- Data would be collected through routine MIS, provider surveys, patient satisfaction and feedback surveys, evaluations and community monitoring

2. Under Component 1, capacities at state, district and sub-district levels would be enhanced for improving data generation and management. Various interventions under the project would help in introducing a “data culture” in the state and also in producing timely, accurate and systematic information for the Department, including for the project. Community level monitoring would also be introduced under the project and capacities for communities to plan and monitor their health outcomes and service delivery would also be introduced.

3. The PCT will be responsible for coordinating with the various directorates collecting this information and conducting necessary surveys and evaluations using appropriately qualified agencies. The TA provider will be tasked with some of these surveys and evaluation, in areas where they are not directly involved in pilots and interventions.
<table>
<thead>
<tr>
<th>Project Development Objective</th>
<th>Project Results Indicators</th>
<th>Use of Project Results Information</th>
</tr>
</thead>
</table>
| To improve the efficiency, quality and accountability of health service delivery in Uttar Pradesh by strengthening the State Health Department’s management and systems capacity | Indicator 1: Percentage of hospitals under the accreditation program that annually produce data and monitor: service productivity, efficiency, quality, patient satisfaction, and accountability [DLI 5] *(efficiency, quality and accountability)*  
Indicator 2: Percentage of districts using the personnel information system for paying salaries of health workers [DLI 1] *(efficiency and accountability)*  
Indicator 3: Percentage of districts with completed and published facility-based report cards detailing national health programs indicators and facility-level performance data [DLI 2] *(efficiency and accountability)*  
Indicator 4: Percentage of Primary Health Centers participating in the social accountability pilots for which a service delivery assessment has been completed and at least one corrective action by government is verified by the community [DLI 4] *(accountability)*  
Indicator 5: Number of facilities using performance based contracts for non clinical services (outsourcing to the private sector for housekeeping and laboratory services) [DLI 6] *(efficiency and quality)*  
Indicator 6: Percentage of hospitals under the accreditation program that have been certified for: (i) entry level pre-accreditation [DLI 7]; (ii) progressive level pre-accreditation accreditation; and (iii) final accreditation *(quality)* | Indicator 1: The indicator monitors the improvement in processes, accountabilities, and systems to report and monitor on various parameters of service delivery (see Table 1 for the list of service monitoring indicators).  
Indicator 2: The indicator measures the accuracy and completeness of the Personnel Information System (PIS), which will be used for key HR decisions.  
Indicator 3: The indicator measures the percentage of districts reporting data using the revised information systems to generate annual district report cards.  
Indicator 4: The indicator measures the responsiveness of service providers to the community demand.  
Indicator 5: The indicator measures the number of hospitals having performance based contracts with the private sector for laboratory and housekeeping services.  
Indicator 6: The indicator measures quality standards of service delivery in hospitals. |
<table>
<thead>
<tr>
<th>Intermediate Outcomes</th>
<th>Intermediate Results Indicators</th>
<th>Use of Intermediate Results Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Component 1. Strengthening the Department of Health’s Management and Accountability Systems</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strategic Planning Functions in the Department of Health</td>
<td>Indicator 1: Number of agreed research studies completed and results disseminated to key stakeholders <em>(efficiency)</em></td>
<td>Indicator 1: The indicator measures effectiveness of the HRKC in supporting planning process with quality inputs and influence policy in key reform areas.</td>
</tr>
<tr>
<td>Improved Data Use for Program Management</td>
<td>Indicator 2: Annual validation of the DRC report for health programs completed <em>(efficiency, accountability)</em></td>
<td>Indicator 2: The indicator monitors</td>
</tr>
<tr>
<td></td>
<td>Indicator 4: Percentage of districts that completed procurement and SCM training of staff <em>(efficiency)</em></td>
<td>Indicator 4: The indicator measures the strengthened capacity in procurement at district level.</td>
</tr>
<tr>
<td></td>
<td><strong>[DLI 3]:</strong> Percentage reduction in procurement cycle time <em>(efficiency)</em></td>
<td>DLI 3: The indicator measures the improvement of procurement cycle time as a result of strengthened capacity across the state.</td>
</tr>
<tr>
<td>Introducing and Strengthening Social Accountability and Provider Incentives</td>
<td>Indicator 5: Pilots for social accountability and performance based incentives designed, implemented and evaluated <em>(accountability)</em></td>
<td>Indicator 5: The indicator monitors the progress in the social accountability pilots at community level.</td>
</tr>
<tr>
<td><strong>Component 2. Improving the Department of Health’s Capacity to Perform Its Quality Assurance Role and More Effectively Engage the Private Sector</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strengthening the Institutional Capacity for Service Quality Improvement and Supportive Regulatory Environment</td>
<td>Indicator 6: Percentage of hospitals: (i) that are connected with Common Treatment Facilities (CTF) services; and (ii) Percentage of accredited hospitals having HCWM monitoring mechanisms and staff trained in HCWM <em>(quality)</em></td>
<td>Indicator 6: This indicator measures the increased environment management capacity of the Health Department.</td>
</tr>
<tr>
<td>Improvement of Quality of Service Delivery at Public Sector Hospitals to Enable Accreditation</td>
<td>Indicator 7: Percentage of hospitals that prepared Action Plan based on facility survey <em>(quality, efficiency)</em></td>
<td>Indicator 7: The indicator monitors the progress in the level of preparedness towards the accreditation program.</td>
</tr>
</tbody>
</table>
Table: Service Delivery Monitoring Framework

<table>
<thead>
<tr>
<th>Project Development Objective</th>
<th>Service Delivery Monitoring Indicators</th>
<th>Use of Outcome Information</th>
</tr>
</thead>
</table>
| To improve the efficiency, quality and accountability of health service delivery in Uttar Pradesh by strengthening the State Health Department’s management and systems capacity | **Data to be included in the annual report from hospitals under the accreditation program are:**  
- **Production**  
  Number of inpatients  
  Number of major surgeries  
- **Efficiency**  
  Average length of stay  
  Bed occupancy rate  
  Surgeries/operating theatre  
- **Quality**  
  Surgical site infection rate  
  Incidence of needle stick injury  
  Net death rate  
- **Equity**  
  BPL patients as % of total patients receiving treatment:  
  Maternity care  
  Lab services  
- **Accountability**  
  Number of complaints received and handled  
  Number of Rights to Information (RTI) cases received and response provided  
  Patient and Employee Satisfaction  
  Tracking of results of annual patient and employee satisfaction surveys  
  **Data to be included in the annual report from primary care facilities under the accreditation program are:**  
  Percentage of districts with at least two First Referral Units (FRUs) offering comprehensive obstetric care according to guidelines; Number of institutional deliveries per year: (i) normal deliveries and (ii) c-sections | The indicator monitors the improvement in processes, accountabilities, and systems to report and monitor on various parameters of service delivery.  
Disseminate performance results and discuss with state, districts and facilities providing inputs for any corrections actions.  
Performance information contributes to resource allocation decisions regarding the continuity and amount of financing.  
Results monitoring will be used to plan further extension and strengthening of the services |
**Project Development Objective (PDO):** To improve the efficiency, quality and accountability of health service delivery in Uttar Pradesh by strengthening the State Health Department’s management and systems capacity

<table>
<thead>
<tr>
<th>PDO Level Results Indicators*</th>
<th>Core</th>
<th>Unit of Measure</th>
<th>Baseline</th>
<th>Cumulative Target Values</th>
<th>Frequency</th>
<th>Data Source/Methodology</th>
<th>Responsibility for Data Collection</th>
<th>Description (indicator definition etc.)</th>
</tr>
</thead>
</table>
| Indicator 1: Percentage of hospitals under the accreditation program that annually produce data and monitor: service productivity, efficiency, quality, patient satisfaction, and accountability (efficiency, quality and accountability) | ☐ | Percentage | Nil | 0 | 30% | 60% | 90% | 90% | Annual | Annual hospital performance report | PCT; Directorate of MH (QA cell) | • **Numerator:** Number of hospitals enrolled under the accreditation program that report hospital performance data for the past fiscal year  
• **Denominator:** Total number (40) of hospitals enrolled under the accreditation program |
| Indicator 2: Percentage of districts using the personnel information system for paying salaries of health workers (accountability and efficiency) | ☐ | Percentage | Nil | 0 | 10% | 30% | 60% | 75% | End of YR2, 3, 4, 5 | Review of six monthly Project progress reports | PCT; DOHFW (Finance Controller) | • Salaries for 7,150 doctors are already fully paid through PIS doctors (7,990 doctors are registered in PIS).  
• Health workers include all employees paid by DOHFW including doctors, nurses, ANMs and paramedics.  
• **Numerator:** Number of districts which have used PIS for disbursing health worker salaries in the last quarter.  
• **Denominator:** Total number of districts (75) disbursing salaries for health workers. |
| Indicator 3: Percentage of districts with completed and published facility-based | ☐ | Percentage | Nil | 0 | 20% | 50% | 75% | 90% | End of YR2, 3, 4, 5 | Review of published district report cards | PCT; Directorates of H&FW (Data) | • National health programs indicators include MCH, nutrition and communicable |
report cards detailing national health programs indicators and facility-level performance data *(efficiency and accountability)*

<table>
<thead>
<tr>
<th>Indicator 4: Percentage of Primary Health Centers participating in the social accountability pilots for which a service delivery assessment has been completed and at least one corrective action by government is verified by the community <em>(accountability).</em></th>
<th>Percentage</th>
<th>Nil</th>
<th>0</th>
<th>0</th>
<th>20%</th>
<th>50%</th>
<th>80%</th>
<th>End of YR 3, 4, 5</th>
<th>Third party validation of assessment reports</th>
<th>PCT</th>
<th>Numerator: Number of PHCs completing the assessment with at least one corrective action by government is verified by the community. Denominator: Total number of PHCs participating the pilot</th>
</tr>
</thead>
</table>

| Indicator 5: Number of facilities using performance based contracts for non clinical services (outsourcing to the private sector for housekeeping and laboratory services) *(efficiency and quality).* | Number | Nil | 0 | 15 | 30 | 50 | 50 | End of YR 2, 3, 4, 5 | Review of outsourcing contracts | PCT; Directorates of MH&FW (PPP cell); QA cell to validate the performance | Numerator: Number of PHCs using non-clinical services including housekeeping and laboratory services. Performance based outsourcing means a portion of payments are linked to quantifiable performance indicators. |

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38 Performance based outsourcing means a portion of payments are linked to quantifiable performance indicators.
**Indicator 6: Percentage of hospitals under the accreditation program that have been certified for:** (i) entry level pre-accreditation; (ii) progressive level pre-accreditation accreditation and (iii) final accreditation (*quality*).

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Nil (^{39})</th>
<th>25%</th>
<th>60</th>
<th>90%</th>
<th>90%</th>
<th>End of YR 2, 3, 4, 5</th>
<th>Review of Accreditation certificates</th>
<th>PCT; Directorate of MH (QA cell)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>0</td>
<td>25</td>
<td>40%</td>
<td>50%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>0</td>
<td>%</td>
<td>10%</td>
<td>25%</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

- **Total number of hospitals is 50.**
- **Definition:** Number of facilities using performance based outsourcing of service contracts.
- **Levels are determined according to standards established by the National Accreditation Board of Hospitals (NABH).**
- **Numerator:** number of enrolled hospitals having received accreditation for (i) entry level pre-accreditation); (ii) progressive level pre-accreditation accreditation and (iii) final accreditation.
- **Denominator:** Total number of hospitals enrolled (40).

**Intermediate Results**

<table>
<thead>
<tr>
<th>Intermediate Result - Component 1. Strengthening the Department of Health’s Management and Accountability Systems</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator 1: Number of agreed research studies completed and results disseminated to key</td>
</tr>
<tr>
<td>Numbers</td>
</tr>
<tr>
<td>----------</td>
</tr>
<tr>
<td>Only 1 pub sector hospital in UP has received a progressive level accreditation at present</td>
</tr>
<tr>
<td>Stakeholders</td>
</tr>
<tr>
<td>-------------</td>
</tr>
</tbody>
</table>
|             | Indicator 3: Percentage of districts that completed training of Financial Management staff | Percentage     | Nil | Nil | 25% | 50% | 90% | 90% | Annual | Project progress reports | PCT; Directorate of H&FW (CMSD) | • Numerator: Number of districts completed training for its staff  
• Denominator: Total number of districts (75) |
|             | Indicator 4: Percentage of districts that completed procurement and SCM training of staff | Percentage     | Nil | Nil | 0   | 25% | 50% | 90% | Six month | Project progress reports | PCT; Directorate of H&FW (CMSD) | • Numerator: Number of districts completed training for its staff  
• Denominator: Total number of districts (75) |
|             | Indicator 5: Pilots for social accountability and performance based incentives designed, implemented, and evaluated | Event/Milestone | Nil | Nil | Pilot's designed, including evaluation framework; Baseline | Implementation mechanisms in place (NGOs hired, performance criteria finalized) and implementation started | Midline evaluation completed | Surveys for end line evaluation with agreed methodology completed | Independent assessment report completed and results shared with stakeholders | Annual | Facility survey; Citizen report cards for PHCs; Household surveys | Hired party agency hired by PCT |
| Indicator 6: | Percentage | Nil | Environmental Management Cell established | Guidelines prepared; Needs assessment for HCWM and Roadmap completed | (i) 50%; (ii) 50% | (i) 65%; (ii) 65% | (i) 85%; (ii) 85%; Independent evaluation completed | Annual | Project progress report and EM cell reports | PCT; Directorate of MH&FW, (EM cell) | (i) Numerator: Number of secondary hospitals that are connected with CTF services  
Denominator: Total number of secondary care hospitals (District Level and FRUs)  
(ii) Numerator: Number of hospitals in the accreditation program determined to have monitoring mechanisms in place and necessary staff trained in HCWM  
Denominator: Total number of hospitals in the accreditation program (40) |
| Indicator 7: | Percentage | Nil | 50 | 90 | 100 | -- | -- | Six month | Project progress report | PCT; Directorate of MH (QA cell) | Action Plan consists of infrastructure, HR, and equipment plan.  
Numerator: Number of hospitals prepared Action Plan  
Denominator: Total number of hospitals (40) |
### Table 2: Disbursement Link Indicators

<table>
<thead>
<tr>
<th>Linkage to PDO</th>
<th>Indicator</th>
<th>Baseline</th>
<th>End of FY 13</th>
<th>End of FY 14</th>
<th>End of FY 15</th>
<th>End of FY 16</th>
<th>Data source</th>
<th>Responsibility for data collection</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accountability and efficiency; PDO indicator 2</td>
<td>DLI 1. Percentage of districts using the personnel information system for paying salaries of health workers</td>
<td>Nil</td>
<td>--</td>
<td>10%</td>
<td>30%</td>
<td>60%</td>
<td>Project progress reports</td>
<td>PCT; DOHFW (Finance Controller, DRC)</td>
</tr>
<tr>
<td>Efficiency and accountability; PDO indicator 3</td>
<td>DLI 2. Percentage of districts with completed and published facility-based report cards detailing national health programs indicators and facility-level performance data</td>
<td>Nil</td>
<td>DRC established and 75% of staff in place with clear TOR; District report card formats developed; and Guidelines issued to the districts</td>
<td>20%</td>
<td>50%</td>
<td>75%</td>
<td>Review of published district report cards</td>
<td>PCT; Directorates of H&amp;FW (Data Resource Centre)</td>
</tr>
<tr>
<td>Efficiency</td>
<td>DLI 3. Percentage reduction in procurement cycle time</td>
<td>To be collected in the assessment report</td>
<td>Assessment completed and accepted by the government, and Action Plan prepared</td>
<td>10% reduction from baseline</td>
<td>20% reduction from baseline</td>
<td>Project progress reports. Independent review of sample contracts</td>
<td>PCT; Directorates of H&amp;FW (CMSD)</td>
<td></td>
</tr>
<tr>
<td>Accountability; PDO indicator 4</td>
<td>DLI 4. Percentage of Primary Health Centers participating in the social accountability pilots for which a service delivery assessment has been completed and at least one corrective action by government is verified by the community</td>
<td>Nil</td>
<td>Pilot design developed, baseline completed, and evaluation framework developed</td>
<td>NGO hired and implementation started in treatment districts</td>
<td>20%</td>
<td>50%</td>
<td>Third party validation of assessment reports</td>
<td>PCT</td>
</tr>
</tbody>
</table>
### Component 2. Improving the Department of Health’s Capacity to Perform Its Quality Assurance Role and More Effectively Engage the Private Sector

<table>
<thead>
<tr>
<th>Efficiency, quality, and accountability; PDO indicator 1</th>
<th>DLI 5. Percentage of hospitals under the accreditation program that annually produce data and monitor: service productivity, efficiency, quality, patient satisfaction, and grievance registration and redressal</th>
<th>Nil</th>
<th>30%</th>
<th>60%</th>
<th>90%</th>
<th>Annual hospital performance report</th>
<th>PCT; Directorate of MH (QA cell)</th>
</tr>
</thead>
</table>

| Efficiency and quality; PDO indicator 5 | DLI 6. Number of facilities using performance based contracts\(^{40}\) for non clinical services (outsourcing to the private sector for housekeeping and laboratory services) | Nil | PPP cell established with at least 75 % of staff in place with clear TOR; Performance based contract format developed for at least 2 outsourcing contracts | 15 | 30 | 50 | Review of outsourcing contracts | PCT; Directorates of MH&FW (PPP cell); QA cell to validate the performance |

| Quality; PDO indicator 6 | DLI 7. Percentage of hospitals under the accreditation program that have been certified for pre-entry level accreditation | Nil | QA cell established and 75% of staff in place with clear Terms of Reference | 25% | 60% | 90% | Pre-assessment reports QA cell reports Six monthly progress reports | PCT; Directorate of MH (QA cell) |

| Total number of DLI targets for each year | 4 | 7 | 7 | 7 | 25 |
| Total expected annual disbursements | US$8 million | US$14 million | US$14 million | US$14 million | US$50 million |

\(^{40}\) Performance based outsourcing means a portion of payments are linked to quantifiable performance indicators.

**Total number of DLIs are 7, with a total of 25 associated DLI targets. Each DLI target has a value of US$2 million.**
Annex 2: Detailed Project Description

INDIA: UTTAR PRADESH HEALTH SYSTEMS STRENGTHENING PROJECT

Component 1: Strengthening the Department of Health's management and accountability systems (total estimated costs US$55 million, of which US$51 million is Bank financing) will support:

- Strategic planning functions in the Health Department
- Improved use of data for program management
- Strengthening accountability in financial management and procurement and supply chain management systems
- Introducing and strengthening social accountability and provider incentives

A. Strategic Planning Functions in the Health Department

1. The state at present lacks a strategic planning function that provides the necessary research and analysis for informed policy decisions. Under the extension phase of the first project, the State entered into an agreement with the Research Cell of Chatrapati Sahuji Maharaj State Medical University (King George’s Medical University) to establish a Policy Analysis Unit (a think tank). This Unit created in mid-2006, undertook analyses of health policy issues and informed key stakeholders on plausible options and strategies, and was successful in generating an environment for presenting such analyses to key stakeholders. Recently, a Health and Knowledge Resource Center (HKRC) has been established by the Family Welfare Department, GOUP, as an autonomous society, for a similar purpose. This is being financed by NRHM, and its main focus is on analytic work related to maternal and child health.

2. Under the project, this strategic planning function will be strengthened by supporting the HKRC to also undertake analytical work and action research in areas beyond maternal and child health such as communicable and non-communicable diseases, health financing, health systems, public health, clinical care and linking financing to results with a focus on equity. This would provide the necessary evidence for policy decision making, and would also help to integrate across the various directorates (and functions) to put in place a more sector-wide approach to planning, budgeting and evaluation systems. With the Health department having taken over implementation of the Health Insurance scheme (RSBY), it is expected that the project would support various technical assistance requirements of the department to implement this scheme in the state.

3. In addition to being a repository of key data, information and knowledge, this cell will function as the think tank for the state’s health department and would:

   - Build partnerships with national and international institutions to build capacity to carry out necessary research and analysis agenda
   - Create to the extent possible a systematic research agenda in select areas mentioned above in addition to providing just in time technical assistance
   - Build capacities in areas such as health systems, health economics and financing, health insurance, public health, clinical service delivery, support systems for healthcare, providing evidence for technical interventions and Health Sector Education and training.
In addition to focusing efforts on current health sector issues (maternal and child health and communicable diseases), would strive to provide insights into emerging issues in the health sector (for example, non-communicable diseases and health insurance)

4. This centre would also be supported by the Data Resource Centre (DRC). The proposed project would finance any additional operating costs of the Unit including contracted staff and consultants hired, as well as the cost of studies, preparation, discussion, publication and dissemination of draft policies for submission to and approval by the Health Department. It would also support TA required for the Unit, including international expertise, and also support the development of such capacities in the academic institutions in the state.

B. Improved Use of Data for Program Management

5. There is a gap in the information environment in the state in terms of timeliness, completeness and quality that impedes informed data driven policy decisions and program management. Disparate information systems exist and survey data is seldom used to inform planning and budgeting. There is weak capacity in the Department of Health to generate, analyze and use data for decision making. In order to improve the management of resources at the Directorate and facility levels, and to enhance the outcomes from the existing parallel disease information systems, an Electronic Data Processing (EDP) Cell is currently functioning in the Directorate but is under resourced and needs strengthening.

6. The proposed project would focus on a three pronged approach to address the above: (i) strengthen the EDP Cell to function as a Data Resource Centre (DRC) to enable better use of data for program management; (ii) strengthen ongoing systems such as the personnel information systems (PIS) to make them into systems designed for transparent decisions related to human resource management; and (iii) introducing new systems such as the geographical information systems (GIS) and those based on the need assessment done by the DRC like a pilot on Hospital Management Information Systems.

7. The Data Resource Center (DRC) would enable better integration of information for decision making from the various information systems and data sources. An important objective would be to ensure that data collected at each level is utilized for improved management of health programs, improvement of service delivery quality and health outcomes, focusing on equity and reducing disparities in access to health care. Institutional data will be linked to community, clinical and epidemiological information. Various sources of data, including national and state surveys, studies (financial, economic, technical) and service statistics data will flow to a data warehouse and the usage of analyzed data in the form of information products by various stakeholders. After the data is collected and analyzed, it will be disseminated to various government departments and made available to other stakeholders, such as donor agencies, researchers etc. Medical equipment inventory management would also be established to support the repair and maintenance function. The DRC would carry out the following functions:

- Act as a repository of all health related data gathered from various sources.
- Analyze various data sources and present key analysis in crisp visual format to strategic planners and policy makers for decision making.
- Support activities carried out on MIS development.
• Provide data, as well as, technical support to health department managers and various administrative units of the health department as and when required.
• Improve quality of HMIS data using data triangulation and statistical quality control techniques
• Develop a “report card” consisting of information on health outcomes, primary care service coverage and health facility performance (production, productivity and quality) to facilitate regular monitoring at district level
• Assist the Department in designing and conducting evaluation studies, program assessments and reviews and in preparation of Monitoring and Evaluation (M&E) plans for pilots and projects

8. **Strengthening Information systems:** The development of the following information systems are also expected to be supported under the project:

• Decision Support Information Systems (DSIS): The project proposes to build upon the work already done under the previous project and the State to enter data of over 95,000 public sector personnel into a Personnel Information System. The proposed system would be upgraded to include attributes such as training status and also include a dynamic query that would make information available for improved Human Resource Management (HRM). For example, the system would be able to query how many facilities have a complement required to provide comprehensive obstetric emergency (anesthetist, obstetrician and pediatrician) rather than have only single query parameters. Such a query mechanism would facilitate more efficient human resource allocations and thereby improve production and quality of health services.

• A Health Geographical Information System (HGIS) is proposed to be developed as a tool for micro level planning and program implementation in the health sector in the state. The GIS will help process and manage a range of health related data including population, disease profile, health care facilities (public and private), health personnel, service outputs, etc. and can be used for a wide variety of applications at the disaggregated level for a number of users and stakeholders. The key objective of this system would be to provide spatial representation of information that could be used for more informed decision making at state and sub-state levels. It is important for the GIS to capture both public and private sector data as the planning can be for the entire health system and not just using public facilities.

9. Based on an assessment study done by the DRC, further Hospital MIS would be developed.

C. **Strengthening Accountability in Financial Management, and Procurement and Supply Chain Management Systems**

**Strengthening Financial Management Systems**

10. For various reasons, different schemes and funds in the health sector flow through different channels. Whereas the state budget flows through the Treasury many other schemes of the GOI are implemented through various state Societies using commercial banking channels. These different channels result in the Health Department not having adequate, timely and comprehensive information on the overall health spending in the state. To overcome this gap, the
information will be presented in the form of a ‘Dashboard’. This Dashboard will consolidate information from various sources and provide comprehensive data (a) at time of budgeting/planning (b) in reporting of actual expenditure. Over a period of time this is expected result in better allocation of resources, prevent overlaps (e.g. in a district), make comparison/analysis more effective, and perhaps even consolidate financial flows. The project would strengthen the use of financial information for improved decision making through the existing accounting and financial reporting systems for treasury and society funds and over time enable the State to move to a unified FM information system, through the Dashboard and by presenting this information to key decision members.

*Strengthening of Procurement and Supply Chain Management Systems*

11. **Procurement:** The Central Medical Stores Department (CMSD), part of the Health and Medical Services Directorate manages the procurement of drugs and medicines for the State at the central level. CMSD procures drugs with 20% of the State budget; the remaining 80% is spent at district level and below. In May 2011, GOUP has changed this, and according to the new policy, CMSD will be responsible for procurement of 80% of the State Drug Budget, while the remaining 20% will be available for the district level and below for drug procurement. CMSD concludes annual rate contracts for drugs which are frequently required such as generic drugs or life saving drugs. All the peripheral units are notified of the rate contracts. These rate contracts are operated by the peripheral units by placement of specific supply orders on the rate contract holding firms. Procurement of Medical Equipment is handled by the Directorate of Medical and Health Services. Procurement of civil works is also handled by Directorate of Medical and Health Services through government agencies such as Uttar Pradesh Rajkiya Nirman Nigam (UPRNN), Uttar Pradesh Power Corporation Ltd (UPPCL) and Uttar Pradesh State Industrial Development Corporation (UPSIDC).

12. **Supply Chain Management:** At state as well as district levels, the demand forecasting is done by adding an increment of about 10% over the previous year’s consumption. In case of centrally sponsored schemes, the demand forecasting is based on methods prescribed in specific schemes. There are warehouses owned by state government as well as centrally sponsored schemes. The state warehouses are located at state, district and block levels. The state does not have an effective Logistics Management Information Systems (LMIS). The Drug Distribution Management System (DDMS) software piloted by UPHSDP did not succeed mainly because of lack of skilled human resources to operate the system. Stock-out and expiry of essential drugs are quite common.

13. The long term goal is to improve the procurement and supply management systems to ensure timely availability of quality drugs, equipment etc. to deliver quality health services in the state of UP. The proposed project would support the State in undertaking the necessary procurement reform and strengthening of procurement and supply chain management systems to achieve this goal.

14. To address the issues described above, following activities will be supported under the Project:
   - An assessment of the current procurement and supply chain management practices in the state of UP will be conducted. For this purpose the study earlier conducted by the Crown Agents (2007) will be taken as base and a consultant will be hired to update the same
• Another study will be taken up to explore feasibility of e-Procurement system for CMSD
• The staff handling procurement and supply management at decentralized level will be trained
• Institutional strengthening of CMSD (in demand forecasting, inventory/asset monitoring, EDL preparation etc.)
• Procurement and SCM related study tour for senior officials to study best practices as well as understand the political economy of procurement reforms

15. Based on the findings of the assessment, further capacity building/system strengthening measures will be taken up.

D. **Introducing and Strengthening social accountability and provider incentives**

**Introducing and Strengthening Social Accountability**

16. In order to improve health services and outcomes, the health system needs to be more transparent and responsive to local needs and demands. Citizens are part of the “health system” and need to play an active role not only as informed clients but also in assisting and holding the system to account. People also need to take greater responsibility for their own health, reducing ill-health and rationalizing the use of services. There are a few examples in UP of initiatives that have some elements of social accountability. For example, a UNICEF-led Integrated District Planning project in Lalitpur district focuses on improving a select list of health and other development indicators through community actions, including interactions with the health system to improve specific health interventions. Through behavior change communication (BCC) coupled with social mobilization and regular monitoring at the village level, the project has been able to improve hand washing and breastfeeding and ANMs’ visits for mother and child health care. Another initiative involves Sahyog, a women’s network in ten districts of the state, which has stimulated local action to monitor and improve the quality of services by enhancing women’s understanding of their health needs and rights.

17. The previous UPHSDP project carried out a maternal death review and proposed a system for reporting maternal deaths that included a “social review” of each death. Related efforts at providing information include Citizens’ Charters at health facilities and grievance redress mechanisms, but these do not yet function effectively where they are needed most. Gram Panchayats are expected to have Village Health and Sanitation Committees (VHSC) which could play a role in developing community actions and health services at the village level provided they receive capacity building and support. Although there have been considerable ‘Information, Education and Communication’ efforts, in the past these have focused largely on giving specific health information and less on helping communities to develop health service accountability. A positive example of the latter is the interpersonal communication by ASHAs on Janani Suraksha Yojana. This has increased community awareness of the benefits of institutional delivery and facilitated women’s use of health facilities, leading to some improvements in the functioning of sub-centers, PHCs, CHCs, etc.

18. Community-based Monitoring (CBM) is a part of the State’s NRHM activities, and has included NGOs carrying out village health mapping, dialogue with different community groups, and IEC for community mobilization. A recent addition is the monitoring of female feticide in
the districts under a Supreme Court mandate to implement the PCPNDT Act against it. CBM has started being implemented but is in its early stages, and hence no lessons are forthcoming.

19. Some social accountability efforts have been undertaken in the health sector in other states, including citizen report cards in Maharashtra and Andhra Pradesh, and in other sectors, notably in NREGA, the national rural employment guarantee scheme, in Rajasthan. While UP’s need for social accountability is vast, the limited experience of social accountability in practice suggests the need for a careful approach to developing the activity under the project.

20. To strengthen social accountability in the health sector, the proposed project would develop, pilot and evaluate model/s for community assessment of health and health care at the local level and use the assessment information to stimulate community action to: (a) demand better services, (b) enhance positive health behaviors and community actions that improve health, and (c) promote community audits of service delivery and drug and human resource availability. These models would be geared to improving equity in health and in access to and utilization of health care. They may also include Panchayati Raj Institutions (PRIs), but would not be limited to PRIs, as these are weak in UP.

21. The project proposes to develop and implement mechanisms at the health facility and village levels that increase the social accountability of service providers and the health system. In the first instance, “social accountability” involves information provision by the health system to its intended beneficiaries to let them know what they can expect from the health services, and citizens reviewing and providing feedback on what they do receive. Then, to be accountable, health providers and facilities need to take corrective action if any problems are identified. Citizens could also, as a result of ‘behavior change communication’ (BCC) (which is both informational and motivational) take responsibility for certain health actions and achieve positive outcomes, thereby facilitating the work of the health system and improving health. It is these complementary and iterative activities – informing citizens, creating simple feedback mechanisms, improving service response, and enhancing community, household and individual health behaviors - that would comprise the social accountability activities under the project, strengthening the most important interface between health services and clients.

22. The long-term objective of this is to build trust among citizens and involve them in improving health service delivery by holding health service providers accountable and increasing their responsiveness to clients’ health needs. The specific objective is to first design and pilot workable approaches to help citizens hold the health system accountable and later the most successful approach/es would be implemented more widely in the state, following assessment of the appropriate scale and areas for expansion.

23. The project would support action research to develop, pilot and evaluate models of social accountability. For the purpose of designing the action research pilots the following activities would be undertaken:

- The experience of existing social accountability efforts in UP and a few relevant ones from other states/countries would be studied in some depth to understand what has been done, in what sequence, how widely, how, and what were the outcomes.
• The roles and responsibilities of all key service facilities and providers will be clarified and the information distilled into materials that are easily presented and understood at the village and facility levels.
• The key known constraints faced by health staff in exercising these roles and responsibilities would be documented so that additional needs to ensure their accountability are addressed in due course.
• A consultative workshop would be organized with key stakeholders to identify some key aspects of the health services where social accountability would be useful and feasible.

24. The approaches and contents of the pilots would be designed on the basis of the above information by a small task force with appropriate expertise and experience. These approaches would be implemented through NGOs or other agencies engaged for the purpose. These agencies would be responsible for developing the approach for further ‘systemic’ implementation. In the case of efforts that have already been piloted, small-scale implementation through the health system could be tested, or they could be expanded in some other manner. The agencies would provide quarterly reports on the processes being followed and achievements, including discussion of problems encountered and how these were resolved. Post implementation, an assessment would be carried out by an independent third party to understand whether the approaches are working and to help develop social accountability for a state wide roll out.

**Award and Incentive System to Improve Provider Accountability in the Public Sector**

25. The public sector has documented problems with provider performance (morale at work, absenteeism, productivity), including in the health sector. Studies indicate absenteeism seen amongst doctors in several developing countries, including India, and this is also observed in UP. In addition to absenteeism, effort is low in the public sector compared to the private sector although skills maybe equal or higher, which to a large extent may be due to a low morale of /lack of incentives for the work force. This is one of the key issues impeding public sector service delivery in the health sector.

26. To address the above; the proposed project aims to address these issues by introducing a system of awards and incentives for health facilities (primary and secondary). Since the State NRHM has already introduced a performance based financial incentives to individuals – ASHA, ANM, medical officer, etc., the proposed project intends to incentivize the health facilities based on results and performance. The project also plans to evaluate the effects of performance based incentives on hospitals and to inform policy makers informed on the results for potential scaling up. The design of the pilots and the evaluation will be done during the first year. The Quality Assurance QA Cell, established in the Directorate would be closely involved in this process, including collecting relevant data from facilities.

**Component 2: Improving the Department of Health’s capacity to perform its quality assurance role and more effectively engage the private sector (total estimated costs US$115 million of which US$101 million is Bank financing) will support:**

• Strengthening the institutional capacity for service quality improvement and supportive regulatory environment
• Improvement of quality of service delivery at public sector hospitals to enable accreditation
Contracting with private sector for improving quality of service delivery
Availability of the full complement of human resources required for accreditation, including health managers

A. **Strengthening the Institutional Capacity for Service Quality Improvement and Supportive Regulatory Environment**

27. This strengthening would include the establishment and capacity building of three critical units in the Directorate: Quality Assurance Cell, Environment Management Cell and Public Private Partnerships Cell. These units would contribute substantially to the sustainability of all interventions, and help bridge some of the long standing gaps in the establishment. Support would also be provided, as required, to implement the recently introduced National Clinical Establishment Act, thereby supporting the role of the government to regulate the quality in the private sector as well.

*Quality Assurance Cell*

28. At present no formal structure/mechanism exists in the Health Department to support, monitor and evaluate the quality of service delivery in the public or private sector. This function becomes even more important with the National Clinical Establishment Act and government health insurance schemes. Therefore, the project would support establishment of a Quality Assurance (QA) Cell in the state directorate with the goal of monitoring the quality of service delivery in the public and private sector, and serve as the technical advisory body to the Directorate for Quality Management Systems in Health. This would involve rolling out of Continuous Quality Improvement (CQI) programs across hospitals, preparing and enforcing minimum licensing standards and supporting hospitals and other health facilities to get accreditation.

29. The activities will include the following:

- Establishment of QA cell
- Define the structure, function and role of the QA cell
- Establish a supportive supervision structure and monitoring mechanism for implementation of CQI and accreditation in the hospitals
- Set and revise regularly, targets to be achieved under the QA process
- Support and guide hospitals to undertake regular internal evaluation
- Prepare a Quality Apex Manual for the QA program in public hospitals
- Guide the state training institutes to undertake training needs assessment for different staff cadres, and develop a system for monitoring and evaluation of training received.

*Environment Management Cell*

30. UP has nine functional Common Treatment Facilities (CTF) established as per the guidelines established under the Bio Medical Waste Management Rules. There are six other smaller, informal treatment facilities which have been authorized and cater to the private sector. Under the previous project, the nine facilities were established under a turn-key approach by which they were contracted to provide treatment and disposal services and also procure consumables and impart training to all facilities. This was an innovative approach but without
the necessary stringent, regular and systematic monitoring and supervision of the operations, along with regular training to CTF service providers. Since this was not rigorously done, there is a need to assess the current system and revise it, if required.

31. It is not recommended that more central treatment and disposal facilities using new technologies be established, but that the guidelines be followed which indicate that one central facility be established to cover a radius of 150 kms and 10,000 beds. This concept prevents proliferation of polluting technology, ensures monitoring by the PCB and also maintains the optimal cost-effectiveness. A mapping exercise will be undertaken to define needs and further requirements of additional CTFs to be established under PPP arrangements. Activities would build on the work done under the first project and further strengthen the institutional mechanisms to regulate and improve healthcare waste management in the public and private sector. This would involve coordinated intra-sectoral (with federal health programs) and multi-sectoral (state pollution control board, municipal authorities) actions as well as the use of Common Treatment Facilities (CTFs) through PPPs or outsourcing constraints for policy implementation.

32. The focus of the first year will be on the establishment of an institutional structure – an Environment Management Cell – which will be responsible for implementation of infection control and waste management activities across the state. The Cell will be constituted in the Department of Health and will be given the mandate to coordinate with other agencies and departments such as Environment and Pollution Control Board, municipal authorities, Public Works Department, Nagar Nigams and Nagar Palikas and PRIs. The monitoring and reporting framework across the different levels of healthcare facilities will be detailed as also the systems for procurement of consumables, training and ongoing capacity building in all healthcare facilities. To implement and monitor activities at all levels, nodal officers at healthcare facilities and at divisional district, and blocks levels will need to be identified.

33. In year’s one-two, a study will be undertaken to assess the current situation of healthcare waste management, the existing gaps and shortcomings of the present system, mapping of existing CTFs and their coverage, evaluation of CTF performance and recommendations for improvement of the existing system. The mechanisms set in place under the first project will be assessed and recommended for revision, if necessary. This study will support the Environment Management Cell in developing an informed road-map on the way forward on this component.

Public Private Partnerships Cell

34. The State is currently drafting a policy for Public Private Partnerships (PPP) in the health sector and is conducting a mapping exercise of PPPs under implementation. A PPP Cell under the Industrial Development Commissioner (IDC), GOUP is functioning. However, till date, this Cell has not been involved much in health-related PPPs, which the government wants to undertake. Creation of a PPP cell within the Health Department is planned with two objectives in mind. The first is to strengthen the performance of ongoing PPPs and outsourcing contracts such as the contracting out of mobile medical units and non-clinical hospital services. The second involves the preparation of new PPP arrangements such as emergency medical services, hospital waste management, voucher schemes, and non-clinical support services.

35. The proposed project will support the establishment a PPP cell, recruitment and training of staff as required, and execution of key functions. A purchasing strategy requires the
establishment of a PPP Cell within the Health Secretariat with the main responsibility for procuring, planning and contracting health services according to population needs. Other roles that can be played by the PPP Cell are:

- **Payer** - in charge of estimating resources needs and look for alternative sources of funds and paying providers
- **Steward** - be the Department in charge of executing PPP policies and collaborating with other units in the definition and implementation of health objectives according to needs and policy priorities
- **Strategist** – prepare strategic plans for PPPs that are aligned with PPP and health policies
- **Contract Manager** - define guidelines and processes for negotiating contracts and to track and assess contracts

The initial role of the PPP cell is detailed below:

36. **Functions of PPP Cell:** Broadly, contracting involves assembling a team to conduct two primary responsibilities: (i) analysis of contracting options and contract preparation, and (ii) contract management and monitoring. The first consists of a series of functions that begins with feasibility assessment ends with signature of contract. The second involves a set of functions that begins once the contract is signed and ends upon contract expiration. In terms of analysis of contracting options and contract preparation, the major functions of a PPP cell are: (i) analyze the problems or gaps in service delivery that can be addressed by PPPs; (ii) conduct market analysis to determine the supply of private providers; (iii) conduct political and legal feasibility analysis or PPP options; (iv) define the services to be contracted (to address a service gap) and targeted beneficiaries; (v) estimate service costs; (vi) set performance measures; (vii) design reporting requirements and monitoring and evaluation system; (vii) set payment mechanisms; (viii) develop tendering procedures and processes and select providers; and (ix) write and negotiate the contract.

37. **Contract management and monitoring consists of the following functions:** (i) make payments in a timely manner; (ii) ensure compliance with contractual terms, including conducting of field inspections, alignment of reported activities with contract specifications; (iii) avoid fraud and corruption; (iv) make sure that financial resources are being effectively used for intended purposes; (v) develop tracking tools and information systems to monitor performance; (vi) maintain regular communication with contractor and detect and solve problems in coordination with contractor(s); and (vii) evaluation.

38. **International experience has shown that contract management and monitoring has been the Achilles heel of PPP arrangements. This relates in part to the fact that service contracts are more complex than contracts for goods or works since they involve a continuous flow of activities. Governments have not established the capacities to monitor contract performance which has contributed to less than expected performance from PPP arrangements.**

39. **Inputs for Establishing the PPP Cell:** The project will provide necessary inputs in human resources, equipment, infrastructure and information technology for the establishment and operations of the PPP Cell. The Key component will be HR and the initial staffing would consist of a lead, professional staff (procurement, accounting and FM, performance management and contract monitoring, information management and data analysis and necessary
administrative and field inspection staff. Legal support, IT management as well as expertise for specific services would also be required and can be contracted out on an as needed basis. However, if the state is considering implementing PPPs on a large scale, say, for example, non-clinical services in hospitals or emergency medical services, it would support the state to have an in-house expert in these areas. Training of staff, based on gap assessment will be conducted in the following areas: contracting cycle; health planning; PPP models; other purchasing models and strategies; legal dimensions of contracting and PPP; negotiation skills; monitoring and evaluation; and performance indicator design; and, impact evaluation.

B. **Improvement of Quality of Service Delivery at Public Sector Hospitals to Enable Accreditation**

40. In India, health systems strengthening and quality of care was brought to centre stage only during late 1990s. The National Board of Accreditation of Hospitals and Healthcare Providers (NABH) under the Quality Council of India has served as a quasi-governmental umbrella body to supervise all efforts of quality, including laboratories since 2005. Till date, NABH has accredited 46 hospitals, and around 336 hospitals are at various stages in the accreditation process.

41. While commitment to quality is now visible in the health sector, scaling-up quality efforts at a state or national level requires overall change in organizational culture. Review of available literature reveals that there are no comprehensive studies on quality care in Indian hospitals. There are also no government-mandated reporting requirements for hospitals. Anecdotal evidence and information from micro studies suggest that hospitals are for the most part inefficiently run, irregularly collect data, and pay little attention to basic measures of quality such as control of infections, adverse events, and patient safety. The state of evidence based quality care is not much different in UP. At the Ram Manohar Lohia Hospital, which was the first public hospital in India to get ‘Provisional Accreditation’ from NABH and supported through the first UP health project, there remain several unaddressed issues as regards the quality management system in both public and private sector. These include: (i) lack of internal audit systems in hospitals to elicit or preempt the problems in the patient and non-patient care areas; (ii) poorly managed health care waste management; (iii) weak information environment for decision making; (iv) lack of clarity of the roles of various hospital systems management committees in the overall quality management of the hospital; (v) no client feedback system; (vi) poor documentation management; (vii) lack of regular clinical skills assessments and comprehensive training plans for clinical staff; and, (viii) lack of standard operating protocols (SOPs) and/or irregular updating of the same.

42. To address the above, the following activities would be supported by the project:

- Facility surveys - identify the gaps in service delivery at 150 district, sub-district hospitals and first referral units -secondary level of health care (a needs assessment has already been completed for 20 hospitals - 17 district hospitals and 3 CHCs) with respect to NABH standards using standard independent assessment mechanisms
- Support development of facility based action plans to support accreditation of these hospitals
- Support, through an Accreditation Challenge Method, selected hospitals to undertake NABH accreditation – 20 hospitals, for which the needs assessment has already been
completed, and approximately 20 additional hospitals, the selection being based on agreed criteria. Any gaps identified for civil works up-gradation would be directly undertaken through state government/NRHM funding; while necessary equipment, technical support and additional human resources required for the accreditation process would be financed by the project.

C. Contracting with the Private Sector for Improving Quality of Service Delivery

**Diagnostic Services**

43. Diagnostic services play a pivotal role in assisting the clinician in patient diagnosis and treatment. However, these services have never been assessed or developed or provided for in a structured manner in the entire state. Current data with the EDP cell of the directorate in UP reports availability of 252 pathologists in the State of UP. Owing to the rapid growth of diagnostic services in the private sector there is lot of internal brain drain from the public to the private especially the pathologists, who are already short in number in state. Shortage apart the variance in the availability of validated data is worrisome. Also, as the technology becomes obsolete every 5 years, it becomes financially non-viable proposition for the government to invest on newer technology every five years and maintain the services at a highly subsidized rate for ensuring accessibility and equity at large.

44. The State has recently experimented on PPPs and outsourcing contracts in the health sector. The Ram Manohar Lohia hospital has outsourced its laboratory diagnostic services to a private laboratory in the city of Lucknow, which maintains a collection centre in the hospital and provides online reports to the hospital as per the agreed contract.

45. The project envisages scaling up the availability of laboratory services in a systematic manner using outsourcing contracts, covering an agreed number of hospitals in selected divisions in the project. Since availability of a defined set of laboratory tests is an accreditation requirement, this would ensure service availability at the hospitals selected for accreditation. It is envisaged that the GOUP will purchase laboratory services from the private player through its non-planned budget for the below poverty line (BPL) patients and subsidy provided to the above poverty line APL patient that would be offered to the (APL) patients. The private player would bear the capital expenditure, expenses of installation, maintenance, and replace of technology when it becomes obsolete. The existing pathologists in the system will be reassigned to the blood banks or relocated to sites where outsourcing services are not yet available. In case of places where contracting of services (diagnostic) are not possible due to non-existence of quality private sector, providing these services through a PPP could also be explored. Based on the feasibility study conducted in the first year of the project, a roll out plan will be prepared that identifies the facilities, services and divisions in which these services will be rolled out.

**Non-Clinical Hospital Support Services**

46. Non-clinical support services at health facilities – cleaning, laundry, kitchen, security and landscaping – are important determinants of quality of service delivery, and often not paid sufficient attention too. Appropriate human resources to deliver the same are either not available in sufficient numbers or there is a high rate of absenteeism amongst them, resulting in poor delivery of these services. Cleaning of the hospital premises as per standards is critical for prevention and control of hospital infections.
47. Hence, non-clinical support services at hospitals, including cleaning would be supported under the proposed project, through outsourcing contracts. The standards required for cleaning would be specified and monitored for compliance. Any of the other support services could also be provided through a PPP, if required.

D. **Availability of the Full Complement of Human Resources required for Accreditation, including Health Managers**

**Availability of Human Resources at Hospitals Selected for Accreditation**

48. NABH Accreditation defines the human resource complement (for all cadres) that is necessary at different levels of hospitals. At present, there are significant vacancies/inadequate positions of different cadres at health facilities in UP, as in most states in India. While the necessary infrastructure and equipment gaps would be relatively easy to provide, ensuring the full complement of human resources would be a challenge for hospitals to achieve accreditation.

49. To address the above, the proposed project, would in collaboration and dialogue with GOUP, support the availability of these human resources, while the infrastructure gaps are being addressed. This would be done by a combination of contractual recruitment, and creation and filling up of essential additional positions. This would ensure that by the time all infrastructure needs are met, and standard processes established, the necessary human resource is also available, thereby negating the risk of health facility under-utilization despite infrastructure upgradation.

**Introducing Health and Hospital Management Professional in Health Facilities**

50. At present, the responsibility for management of the health facility rests with the facility in-charge (Chief Medical Superintendant – CMS). This person is a qualified doctor, however, has never been provided any formal management training to perform the desired tasks efficiently and effectively. Also, the facility in-charge could potentially significantly be assisted by a ‘hospital manager / administrator’, who need not necessarily be a doctor by profession, but be trained in management. Similarly, the Chief Medical Officer (CMO) has the responsibility of oversight of all public health programs in a district, but has often not been specifically trained in public health management.

51. To strengthen managerial capacities, the proposed project plans to address the above described capacity weakness by supporting the following: (i) creation of a hospital manager/administrator position and recruitment of professional hospital managers; (ii) in-service management training (through scholarships) of selected medical officers and their subsequent recruitment into the newly created position; (iii) short-course in-service training programs for CMS/CMO/ matrons to provide defined management skills; and (iv) candidates to do a Masters in Public Health (MPH) course and subsequently be posted as CMOs.
Annex 3: Implementation Arrangements

INDIA: UTTAR PRADESH HEALTH SYSTEMS STRENGTHENING PROJECT

Situational Analysis:

1. The key to the successful delivery of this project lies in establishing a clear line of communications between the three directorates involved in its various components. The directorates are, Medical Health (MH), Training (T) and Family Welfare (FW).

2. Additional challenges are the shortage of staff with appropriate skill sets in sanctioned positions, this is particularly noticeable in the area of mid level government officers. The management challenge will be the co-ordination and motivation of the stakeholders and ensuring that appropriate human resources are in position, with a clear understanding of their roles by the time this project becomes effective.

3. The proposed implementation approach envisages locating specialist support cells within the Directorate of Medical Health. The Department of Medical Health has space constraints and the additional challenge of housing the Project Co-ordination Team (PCT), Public Private Partnership (PPP), Data Resource Centre (DRC), Quality Assurance (QA) and the Hospital Waste Management cells.

Proposed Implementation Structure:

4. A Project Governing Board (PGB) has been established under the Chairmanship of the Chief Secretary, Government of Uttar Pradesh to provide overall direction, approval of posts and financial and legal sanctions for the project. The PGB will delegate powers to the Project Steering Committee (PSC) and PD in the interest of efficiency in the execution of project activities.

5. The PSC under the Chairmanship of the Principal Secretary Medical, Health and Family Welfare, will consider proposals placed before it by the PD. The PSC will meet at least once a quarter. The PD will have delegated financial and procurement authority from the PGB for hospital equipment, supplies and consultancy contracts, as well as organizing selection committees to select staff for project posts.

6. There will be a three tier structure (see Annex 3) for the day to day implementation of this project consisting of, (i) the Project Co-ordination Team (PCT) headed by the Project Director (PD), (ii) specialist support cells located within the Directorate of Medical Health, and (iii) a Project Support Unit (PSU) which will provide dedicated support to the PCT, the specialist support cells and other technical assistance needs of the Directorate and the Department.

7. The PCT will be responsible for overseeing the timely and effective implementation of the project. It will be led by the PD, who will be supported by an additional project director (APD), who will be responsible for the overall day to day activities and supervision of the project. In addition, the PCT will have team members drawn from the Departments of Medical Health and Family Welfare (DOHFW) and their respective Directorates.
8. Specialist support cells located within the Directorate of Medical Health will support institutional strengthening, and will be responsible for implementing and managing activities supported under the project, related to their respective areas. The support cells are Quality Assurance, Public Private Partnership, Electronic Data Processing (EDP) Data Resource Centre and Environment Management.

9. The PSU supported by the TAP will be used to build institutional capacity within the Directorate of Health to enable it to implement various project activities (see figure in Annex 3: Implementation Arrangements). The Directorate of Medical Health will be responsible for implementing and/or managing project activities in coordination with the Directorates of Family Welfare and Training, other sectors (such as the State Pollution Board for environment management) and other related non-state institutions (such as NABH, NGOs and the private sector).

10. The Project Support Unit (PSU) will consist of staff specialized in areas relevant to the core needs of the project. The structure and specialists will reflect the need to support the specialist cells, implement innovative pilots and manage the fiduciary requirements of the project. Depending on the skills required, either medical staff would be seconded from the Directorates of Medical and Health and Family Welfare or where there is a lack of capacity within the department, consultants will be hired. A procurement agent (PA) will be contracted to carry out the procurement of goods, works and non-consulting services for the project. This PA would also be responsible for building procurement capacity and developing procurement systems within the Central Medical Stores Department (CMSD) and at the decentralized level. A Technical Assistance Provider (TAP) will provide TA consultancy support, as well as contract and manage external TA as required. Both the PA and the TAP will be supervised by the PSU under the oversight of the PCT.
Figure 1: Implementation arrangement of the UPHSSP

**UPHSSP**

- Project Governing Board (PGB)
  - Chaired by Chief Secretary, Govt. of UP

- Project Steering Committee (PSC)
  - Chaired by Principal Secretary, MoHFW

- Project Coordination Team (PCT)
  - Project Director

- Project Support Unit (PSU)
  - Fiduciary compliance (FM, Proc, M&E)
  - Support to Directorate cells (TA provider & Procurement Agent)

**Department of Medical Health and Family Welfare**

- Directorate of Medical Health and Family Welfare
  - Quality Assurance Cell
  - Data Resource center
  - Environment Management Cell
  - Public Private Partnership Cell
  - Central Medical Stores Dept.

**Facilities:**
- District Hospital
- Primary Health Center
- Community Health Center
- Sub Center
Financial Management and Disbursements

11. The Project will be implemented by the DOHFW and will, to a large extent, use the existing financial management (FM) systems of GOUP. The project activities will be mainly managed by the PSU with implementation of specific activities by approximately forty hospitals. The FM arrangements of the project are based on use of the FM country systems with the additional features of separate financial reporting and internal audit arrangements for additional fiduciary assurance. Overall these arrangements are considered adequate to meet the Bank’s requirements as described below.

Background and State Context

12. The Bank had implemented the UPHSDP (P050657) in the state during the period 2000 – 2008. Key FM aspects of the project were: (a) for inventory/assets, the validation between physical and financial information was not carried out regularly, focus on effective utilization of assets was weak, and in some cases assets purchased were not put to use; (b) streamlining release of project funds could have been improved by providing flexibility in spending within an overall budget ceiling for the implementing entity instead of tying release orders to specific activities; (c) audit reports focused on eligibility of expenditure for reimbursement rather than on overall certification of financial statements and reports were delayed in some years; and (d) internal audit arrangements were not adequate. Other projects in the state are faced with issues of weak internal controls and sometimes non-adherence with FM guidelines.

13. An assessment of the FM arrangements was carried out which included the collection of data/information, discussion on various arrangements for the implementation of contracts/activities, institutional aspects, risk mitigation measures, meetings with the Project team/Directorate/Finance Department, and several rounds of discussion on the project FM Manual.

14. These lessons learned have gone into design of the project institutional/fiduciary arrangements which include: (a) use of mainstream government systems of budgeting and financial control; (b) centralized procurement and a fairly centralized payment system; (c) regular internal audit; (d) use of treasury data as basis of financial reporting; and (e) strong statutory audit arrangements. These arrangements are described in the subsequent sections.

Budgeting

15. The State Government will make an annual allocation for the project as part of the budget of the Health Department under a separate head\(^\text{41}\) titled ‘Externally Aided Projects’. This will be based among other things on the Procurement Plan, inputs from various implementing units, and cost tables. The budget would be approved by the State Legislature as part of the overall budget of the Department. For the DLIs, the Bank will finance a share of salaries/allowances paid to staff under the DOHFW. Codes have been allotted to the project under which (a) a budget will be approved by the state legislature (this will authorize the implementing agencies to spend on project activities); (b) periodically a budget will be ‘released’ to enable payments; (c) all accounting locations will authorize payments (approve bills) and send the same to the Treasuries

\(^{41}\)Two heads (2210-01-110-97-01/02-xx) will be created to mirror the two Project components
for further processing; and (d) the Treasuries will issue pay orders favouring the payee, and record the payment under the relevant budget head.

**Accounting/ Staffing**

16. Accounting will be done on a cash basis using government systems; expenditure will be recorded and reported at time of final payment for goods, services, and other expenditures. Rules for accounting will be guided by the State Financial Handbook (in eight volumes) and Budget Manual as applicable to all transactions in UP. Together these documents lay down policies and procedures for the entire FM cycle from budgeting to accounting/ internal controls and also prescribe formats for reporting and record keeping. A significant part of the payments will be made at the PSU in Lucknow with limited financial powers be delegated to some forty hospitals to enable them to make recurring payments for contractual staff/ activities under pre-specified consultancy contracts. Adequate records will be maintained at accounting locations and will include vouchers, invoices, cash books, ledgers and asset registers. The project FM arrangements are documented in form of a Financial Management Manual (FMM) which refer to the relevant state rules and provide guidance on budgeting, funds authorization, accounting, internal controls, reporting and audit arrangements. Thus a high level of reliance is placed on ‘use of country systems’.

17. The Finance Function in the Department will be headed by a Finance Controller who will provide overall guidance. At the PSU, the FM function will be discharged by an Officer from the Finance Department in full time capacity who will be supported by an experienced Consultant and adequate number of support staff (accountants). At the hospitals, the FM function will be discharged by the existing accounting staff.

**Internal Control and Internal Auditing**

18. Project FM arrangements will include the following arrangements for internal controls (a) processing of all payments by the UP Treasuries which are independent of the DOHFW (since they are part of the State Finance Department) and which will review, check compliance and only then approve payments. Personal Ledger Accounts/ Deposit or commercial bank accounts will not be used at any level; (b) periodic financial reporting and (c) regular Internal Audit (IA). The IA function under the project will be entrusted to a firm of Chartered Accountants. The qualifications of the firm and Terms of Reference for audit will be subject to a review by the Bank. The audit will be on a periodic basis and would review transactions on a reasonable sample basis, the results of this audit would form the basis for management action. Action taken by the management will be reviewed by the Bank during regular project supervision.
Consolidation of Health Sector Financial Information

19. For historic reasons, various schemes and funds in the sector flow through different channels. Whereas the state budget flows through the Treasury many other schemes of the GOI are implemented through state Societies using commercial banking channels. These different channels result in the Head of Department not having adequate, timely and comprehensive information on the overall health spending in the State. To overcome this gap, a study is proposed to present the information in form of a ‘Dashboard’. This Dashboard will consolidate information from various sources and provide comprehensive data (i) at time of budgeting/planning; and (ii) in reporting of actual expenditure. Over a period of time this will result in better allocation of resources, prevent overlaps (e.g. in a district), make comparison/analysis more effective, and may also result in consolidation of financial flows.

Funds Flow and Disbursement Arrangements

20. Funds will flow from the Bank to the GOI and on to the GOUP. A Special Account will be opened by GOI with the Reserve Bank of India to receive funds under the project. Unutilized credit, if any, at completion of the project activities would be repaid to the Bank. In the GOUP’s budget, Project funds will be budgeted as a budget line item under the Health Department; the Department will allocate the required budget to each accounting location to be able to draw on and make payments. Funds flow arrangements are presented in the diagram below.
21. The Project will submit semi-annual Interim Financial Reports (IFRs) which will provide information on expenditure made (duly reconciled with Treasury Reports) in the previous semester and forecast for the subsequent semester. Semi-annual disbursements would be made based on these IFRs, reimbursing expenditure for the reporting period. IFRs will be submitted to the Bank within 45 days of close of the semester. For the purposes of disbursement the Funds will be allocated as follows.

<table>
<thead>
<tr>
<th>Disbursement Category</th>
<th>Category 1</th>
<th>Category 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td>Traditional Disbursement</td>
<td>DLI based Disbursement</td>
</tr>
<tr>
<td>GOUP Allocation</td>
<td>US$18 million equivalent</td>
<td>Nil</td>
</tr>
<tr>
<td>Bank credit allocation</td>
<td>US$102 million equivalent</td>
<td>US$50 million equivalent</td>
</tr>
<tr>
<td>Eligible expenditure</td>
<td>Goods, works, non-consulting services, and consultants’ services, training and operating costs under the Project</td>
<td>Salaries and Allowances – Salaries and Dearness Allowance paid under Grant Nos. 32 (Medical – Allopathy) and 35 (Family Welfare)</td>
</tr>
<tr>
<td>Disbursement method/cycle</td>
<td>85% of eligible expenditure based on semi-annual IFRs</td>
<td>100% upon achievement of DLI as per independent verification and audits/ Annual</td>
</tr>
<tr>
<td>Linked with</td>
<td>Specific project inputs under Component 1 and 2</td>
<td>DLIIs linked with Component 1 and 2</td>
</tr>
<tr>
<td>Disbursement condition</td>
<td>None</td>
<td>Achievement of DLI targets</td>
</tr>
</tbody>
</table>

An advance of up to US$10 million may be requested by the Project anytime during the lifetime of the project; this will be recovered from disbursements that are made close to closure of the project period.

22. The project components have specific project inputs that will be financed by the project as well as disburse against agreed DLIIs as described in section III A. The description of specific project inputs is provided in the table below followed by the DLIIs linked to each of the components.

**Specific project inputs for Component 1: Strengthening the Department of Health’s management and accountability systems:** The specific inputs to be supported under this component include consultant services (conducting studies, providing technical assistance and training), non-consulting services (GIS data), non-clinical equipment (Information Technology related hardware and networking equipment), hiring of non-governmental organizations to implement social accountability pilots, performance awards to facilities (provider incentive pilots) and operating costs (workshops, contractual staff for cells and other operating costs of project).

**Specific project inputs for Component 2: Improve the Department of Health’s capacity to perform its quality assurance role and more effectively engage the private sector:** The specific inputs to be supported under this component include consultant services (conducting studies, providing technical assistance, training, handholding of facilities to achieve accreditation, accreditation fee), non-consulting services (outsourcing of diagnostic and housekeeping services), clinical equipment for hospitals undergoing accreditation) and operating costs (workshops, contractual staff for cells and facilities).
Disbursements Linked Indicators (DLIs)

23. A part of the project activities will be financed using DLIs as explained in Section III B; Project Financing. The disbursement against DLIs would be on achievement of agreed indicators and targets are given below and in Annex 1 of the PAD in the “DLI Table”. There will be four rounds of annual disbursement in 2013, 2014, 2015 and 2016. There are 7 DLIs with 25 associated DLI targets over the project period. Each DLI target will have a value of US$2 million totaling to US$50 million over the project period. Each DLI is independent of each other, i.e., non-achievement of some DLI targets for a year will not hold up disbursement against other DLI targets that have been achieved for that year. The DLIs would be “floating” where non-achievement of a DLI target can be carried over to the next year to a maximum of one year. The achievement of the indicators will have a system of independent verification which is explained in the PAD section titled ‘Results Monitoring and Evaluation’.

Table: Disbursement Linked Indicators

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Baseline</th>
<th>End of FY 13</th>
<th>End of FY 14</th>
<th>End of FY 15</th>
<th>End of FY 16</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Component 1: Strengthening the Department’s of Health management and accountability systems</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DLI 1. Percentage of districts using the personnel information system for paying salaries of health workers</td>
<td>Nil</td>
<td></td>
<td>10%</td>
<td>30%</td>
<td>60%</td>
</tr>
<tr>
<td>DLI 2. Percentage of districts with completed and published facility-based report cards detailing national health programs indicators and facility-level performance data</td>
<td>Nil</td>
<td>DRC established and 75% of staff in place with clear TOR; District report card formats developed; and Guidelines issued to the districts</td>
<td>20%</td>
<td>50%</td>
<td>75%</td>
</tr>
<tr>
<td>DLI 3. Percentage reduction in procurement cycle time</td>
<td>To be collected in the assessment report</td>
<td>Assessment completed and accepted by the government, and Action Plan prepared</td>
<td>10% reduction</td>
<td>20% reduction</td>
<td></td>
</tr>
<tr>
<td>DLI 4. Percentage of Primary Health Centers participating in the social accountability pilots for which a service delivery assessment has been completed and at least one corrective action by government is verified by the community</td>
<td>Nil</td>
<td>Pilot design developed, baseline completed, and evaluation framework developed</td>
<td>NGO hired and implementatio n started in treatment districts</td>
<td>20%</td>
<td>50%</td>
</tr>
<tr>
<td><strong>Component 2: Improving the Department of Health’s capacity to perform its quality assurance role and more effectively engage the private sector</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DLI 5. Percentage of hospitals under the accreditation program that</td>
<td>Nil</td>
<td>30%</td>
<td>60%</td>
<td>90%</td>
<td></td>
</tr>
</tbody>
</table>
annually produce data and monitor: service productivity, efficiency, quality, patient satisfaction, and grievance registration and redressal

<table>
<thead>
<tr>
<th>DLI 6. Number of facilities using performance based contracts for non clinical services (outsourcing to the private sector for housekeeping and laboratory services)</th>
<th>Nil</th>
<th>PPP cell established with at least 75 % of staff in place with clear TOR; Performance based contract format developed for at least 2 outsourcing contracts</th>
<th>15</th>
<th>30</th>
<th>50</th>
</tr>
</thead>
<tbody>
<tr>
<td>DLI 7. Percentage of hospitals under the accreditation program that have been certified for pre-entry level accreditation</td>
<td>Nil</td>
<td>QA cell established and 75% of staff in place with clear Terms of Reference</td>
<td>25%</td>
<td>60%</td>
<td>90%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Total number of DLI targets for each year</th>
<th>4</th>
<th>7</th>
<th>7</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total expected annual disbursements</td>
<td>8</td>
<td>14</td>
<td>14</td>
<td>14</td>
</tr>
</tbody>
</table>

Each DLI has a value of US$2 million. There a total of 7 DLIs and a total of 25 associated DLI targets

24. World Bank guidelines on Investment Lending require that disbursement take place against an activity that is eligible for Bank financing. “Salaries and Dearness Allowance paid under Grant Nos. 32 (Medical – Allopathy) and 35 (Family Welfare)” would be considered as the Eligible Expenditure Program (EEP[^42]) which the DLIs would fund.

25. An assessment of the system of payments of salaries in the health department was carried out. This included review of the Personnel Information System (PIS), its interface with the UP Treasuries and the final payment of salaries directly into bank accounts of staff. The PIS is already being used as a base for recording of HR data/ salaries for Doctors and is expected to expand to cover other health sector staff in the next few months. Since disbursements are based on Audit Reports, fiduciary risk under this component is considered acceptable.

26. Expenditure reported on the EEP would be based on independently audited financial statements; the Comptroller and Auditor General of India (CAG) through its offices in UP is the auditor for the state including the Health Department. The CAG’s audit report will be reviewed to confirm actual expenditure on the EEP which should be greater than the disbursement made. The audit process will be completed in the following manner (a) GOUP will provide the following documents: State Finance Accounts and Appropriation Accounts (issued by the AG (A&E)); State Audit Report (issued by the AG (Audit)) to review observations relating to the EEP if any; and Grant-wise expenditure details (issued by the Finance Department). All these are

[^42]: Expenditure recorded on the EEP for FY 2009-10 was Rs. 2370.82 crores
standard documents which are publicly available. (b) Since object head-wise details are not available in the documents issued by the AG, the health department will annually carry out reconciliation between the Appropriation Accounts and the Grant-wise expenditure details. Once reconciled\(^43\) the values as available from the Grant-wise expenditure details will be considered as the EEP.

27. These reports are issued by the CAG and are made public only after they are placed before the State Legislature; further—there is a weak co-relation between the timing of inputs and outputs. Taking this into consideration the disbursement cycle will be as follows.

<table>
<thead>
<tr>
<th>Year</th>
<th>DLI verification</th>
<th>Disbursement/audit due date</th>
<th>US$ Million</th>
<th>Eligible Expenditure</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Apr 2013</td>
<td>Jun 2013</td>
<td>08</td>
<td>Apr 11 – Mar 12</td>
</tr>
<tr>
<td>2</td>
<td>Apr 2014</td>
<td>Jun 2014</td>
<td>14</td>
<td>Apr 12 – Mar 13</td>
</tr>
<tr>
<td>3</td>
<td>Apr 2015</td>
<td>Jun 2015</td>
<td>14</td>
<td>Apr 13 – Mar 14</td>
</tr>
<tr>
<td>4</td>
<td>Apr 2016</td>
<td>Jun 2016</td>
<td>14</td>
<td>Apr 14 – Mar 15</td>
</tr>
</tbody>
</table>

28. The cycle of disbursement on achievement of the agreed performance indicators and the subsequent confirmation (by Audit) of the eligible expenditure for which it was made, will be repeated each year.

**Auditing (for the project other than for the DLIs)**

29. The CAG of India through its office in UP will be the statutory auditor for the project. The CAG will conduct an annual audit of the Project as per a Terms of Reference that has been agreed with the CAG for all Bank Projects in India; the audit report will be submitted to the Bank within six months of the close of each financial year; the report will also be displayed on the GOUP/Project website. The Directorate/PMU will review the audit findings to ensure that necessary corrective action including the timely settlement of observations/disallowances.

30. The following audit reports will be monitored in ARCS (Audit Report Compliance System) of the Bank:

<table>
<thead>
<tr>
<th>Audit Report</th>
<th>Implementing Agency</th>
<th>Due Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project Audit Report issued by the CAG</td>
<td>UPHSS Project</td>
<td>September 30</td>
</tr>
<tr>
<td>Special Account</td>
<td>DEA/GOI</td>
<td>September 30</td>
</tr>
</tbody>
</table>

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\(^43\) A reconciliation was successfully carried out for FY 2009 – 10 during project preparation
Plan for implementation support

31. In the light of the arrangements as explained above, the FM risk is rated as ‘Substantial’. This will be regularly evaluated during the project period. FM interventions on the project will review the operation at accounting locations, internal controls, staff capacity and ensuring a robust system of monitoring/ internal audit. Support will also be aware of developments/ changes in the areas of Public Financial Management and financial management performance of other projects in the State.

Procurement

32. The Project comprises of two components namely, strengthening systems and management (Component 1) and improving quality of service delivery (Component 2), in addition to project implementation and management expenditures. All these components will involve procurement of works, goods, consultancy and non-consultancy services. Procurement under the project would be conducted only at Central level and no decentralized procurement is envisaged.

33. Procurement for the project will be carried out in accordance with the World Bank’s “Guidelines: Procurement of goods, works and non-consulting services under IBRD loans and IDA credits & grants by World Bank borrowers” dated January 2011 (“Procurement Guidelines”) and “Guidelines: Selection and employment of consultants under IBRD loans and IDA credits & grants by World Bank borrowers” dated January 2011 “(Consultant Guidelines)”.

A. Procurement Capacity

34. The Central Medical Stores Department (CMSD), part of the Health and Medical Services Directorate conducts the procurement of drugs and medicines for the State at the central level. As per the revised drug & equipment policy, CMSD procures drugs with 80% of the State budget; the remaining 20% is spent at district level and below. CMSD concludes annual rate contracts for drugs which are frequently required such as generic drugs or life saving drugs. All the peripheral units are notified of the rate contracts. These rate contracts are operated by the peripheral units by placement of specific supply orders on the rate contract holding firms. In the budget for drugs procurement, a portion is earmarked for procurement from Uttar Pradesh Drugs & Pharmaceuticals Limited (UPDPL), which is a company owned by the state government. Procurement of Medical Equipment is handled by the Directorate of Medical and Health Services. The records of centralized procurements done at the state level are being maintained on computers to some extent. But, the supplies received at district level facilities are still being maintained manually at most of the places. It is not possible for all batches of centrally procured drugs to be tested prior to delivery because of immense workload at FDA Labs and these drugs are subsequently transferred to districts. Hence quality maintenance is an important issue. The drugs obtained through rate contract at the district level are tested randomly; hence quality issue needs to be also addressed. Sometimes local suppliers quote unrealistically low prices to get themselves enlisted for rate contracts and are thus unable to supply the drugs to distant areas. Furthermore, there are instances of short supply and compromising on quality.

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44 An amount of US$ 50 Million is being allocated for DLIs under the Project. The underlying expenditure for these DLIs will be staff salaries thus not including any procurement contracts.
35. Procurement of civil works is also handled by Directorate of Medical and Health Services through government agencies such as Uttar Pradesh Rajkiya Nirman Nigam (UPRNN), Uttar Pradesh Power Corporation Limited (UPPCL) and Uttar Pradesh State Industrial Development Corporation (UPSIDC). These agencies follow the state financial rules, which are quite different from Bank Guidelines, for conducting the procurement.

36. At the district level, procurement is done by doctors, who are entrusted with this task apart in addition to their normal duties. It is unrealistic to expect them to be able to effectively manage the procurement process, including estimation of requirements, buffer stocks, etc., particularly when they have not been trained for it. In quite a few districts the space for storage of drugs is inadequate.

37. At state as well as district levels, the demand forecasting is done by adding an increment of about 10% over the previous year’s consumption. In case of centrally sponsored schemes, the demand forecasting is based on methods prescribed in specific schemes. There are warehouses which are owned by state government as well as centrally sponsored schemes. The state warehouses are located at state, district and block levels. The state does not have an effective Logistics Management Information Systems (LMIS). The Drug Distribution Management System (DDMS) software piloted by UPHSDP did not succeed mainly because of lack of skilled manpower to operate the system. Stock-out and expiry of essential drugs is quite common. However, some steps have been initiated recently towards strengthening the procurement system including the construction and renovation of drug warehouses.

38. Based on the assessments conducted as well as the experience of implementation of the predecessor project, it may be concluded that the procurement capacity in the state is inadequate particularly in view of increasing funding from the National Rural Health Mission (NRHM) as well as the health budget of the government of UP. Apart from procedural violations, another area of concern is delays in decision-making. There are also reports of financial irregularities and instances of fraud and corruption (F&C) in procurement under NRHM, but these allegations are yet to be established as investigations/audits by government agencies are ongoing.

39. On the projects implemented under the public private partnership (PPP) model, the state government has initiated a dedicated PPP Cell under the Industrial Development Commissioner (IDC)/Principal Secretary Industrial Development for the government of Uttar Pradesh. In the past the PPP model was used for some services in health sector, for example contracting out of Non-Clinical Services to Private Providers, Hospital Waste Management, outsourcing of Janitorial, Gardening and Laundry Services at hospitals, Mobile Health Clinic for remote areas of the state, Emergency Medical Transport Services etc. However there is no dedicated PPP cell in the state health department.

B. Procurement Arrangements under the Project

40. The day-to-day procurement function (procurement planning and monitoring, coordination of the procurement agent/TAP and technical cells, reporting and coordination with the Bank, implementation of procurement risk mitigation plan etc.) under the project will be looked after by two procurement experts already in place (one in-charge of goods/works and another for the consultancy/non-consultancy services), who are part of Project Support Unit (PSU). These procurement experts were involved in the predecessor project and are well conversant with the Bank’s Guidelines. These procurement experts will report to the APD or
Joint Director (procurement), who are to be deputed from CMSD. A Project Coordination Team (PCT) under the chairmanship of the Project Director and consisting of procurement, FM and functional experts will be responsible for the overall implementation of the Project. The PCT will in turn work with the Departments of Medical Health and Family welfare (MH&FW) and Medical Education and their respective Directorates of Training, Medical Health, Family Welfare and Medical Education. A Project Steering Committee (PSC) under the chairmanship of Principal Secretary (Medical, Health and Family Welfare) and consisting of Secretary (Health), Secretary (FW), Secretary (Finance), Project Director, Chief Engineer (PWD), DG (Medical and Health), DG(Family Welfare) and special invitees will take all financial decisions.

41. It is estimated that the Project will involve procurement of about US$65 Million. The Project has agreed to enhance the financial delegation to PCT and PSC in order not to delay procurement related decisions.

42. Procurement Arrangements for Goods, Civil Works and Non-Consulting Services: Due to the weak procurement capacity of the implementing agencies, a professional procurement agent (PA) will be hired to handle the procurement of Goods, Works and Non-Consulting Services (including outsourcing of pathological, cleaning and gardening services). The procurement agent will also be responsible for skill transfers to CMSD as well as procurement capacity building in CMSD and at the decentralized level. The procurement agent will report to Additional Project Director (APD)/Joint Director (Procurement) and will work closely with procurement experts of the PSU. While the PA will issue the contracts, the payments for these contracts shall be handled by the PSU. PA will also handle the contract management responsibilities. Additionally, the Remote Sensing Applications Centre (RSAC) under the Department of Science and Technology, Government of UP (which will act as sub-implementing agency) will handle some procurement related to Health Geographical Information Systems (HGIS). RSAC has earlier handled procurement of similar items under Bank supported U.P.Sodic Land Reclamation project-III.

43. Procurement Arrangements for Consultancy Services: A Technical Assistance Provider (TAP) will be selected to provide various consultancy services planned under the Project. While the TAP will use its in-house team or the panel of experts on the technical consultancies, it will help the PSU to contract the consultants in remaining cases. The TAP will also assist the PSU and technical cells on contract management for all the consultancies.

44. Procurement Arrangements for PPP Services: In case the PPP service provider is selected through open competitive bidding procedure acceptable to the Bank, the service provider will not be required to follow the procurement guidelines for acquiring the input goods/works/services. However, if the service provider is selected without following an acceptable open competitive process, it will be required to follow the agreed procurement procedure including using the procurement agent for procurement of inputs for implementing the project. The proposed PPP cell will provide technical inputs for PPP contracts while the procurement agent will support the bidding process.

45. Decentralized Procurement: No decentralized procurement is currently envisaged under the Project because of weak capacity. However if the capacity is improved and considered satisfactory in future, decentralization of procurement may be considered.
46. E-Procurement: As of now the state does not use e-Procurement system. However, if needed in future, the e-Procurement may be permitted up to NCB threshold provided the system proposed to be used is assessed and found acceptable by the Bank.

47. Strengthening of Procurement and Supply Management under the Project: The project will assist the government in strengthening and improving the procurement and supply chain management systems in the CMSD to ensure timely availability of quality drugs, equipments and other supplies in order to deliver quality health services in the state. This may also include moving to an e-procurement system.

48. Monitoring and Supervision of Procurement: PSU will act as single point of contact for the Bank for the purpose of implementing/monitoring the agreed procurement arrangement under the Project (including the procurement handled by RSAC). The PSU will prepare a consolidated summary report containing important information on the progress on the procurement, providing details such as the name of the contract, estimated cost, actual cost, date of invitation, date of opening, number of bids received, number of bids considered responsive and date of award of contract. The progress report will also contain information on contracts awarded within the original validity of bids and those awarded with extended bid validity, percentage of contracts awarded in the first/second/third call, the implementation status, number of conferences carried out to build capacity of bidders etc. The format for the consolidated report on prior review contracts (which will be submitted to the Bank on quarterly basis as part of IFR) will be agreed with the Bank by PSU. The information received by PSU and Bank’s Implementation Support missions will be analyzed by the Project and an action plan to remedy the situation and take corrective measures will be prepared and agreed with the Bank.

49. Procurement Risk Assessment: The following table lists major procurement related risks and the mitigation plan. The project will finance procurement and supply management capacity building as a separate sub-component, which is likely to mitigate risk in the medium term. The risk ratings have been decided based on both the probability of occurrence of various events (including F&C risks related to procurement) as well as their likely impact. Based on the risk factors, the overall residual procurement risk rating for the project is determined as “Substantial”.
<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Initial Risk</th>
<th>Mitigation Measure</th>
<th>Completion Date</th>
<th>Residual Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Limited capacity and inefficiencies resulting in delays in procurement process</td>
<td>High</td>
<td>Use of a procurement agent (PA) to handle the procurement Goods/Works on turn-key basis and TAP to assist in selection of consultants. Use of skilled procurement staff for monitoring PA and handling procurement of services. Adequate delegation for decision making. Monitoring through procurement plan and quarterly reports.</td>
<td>RFP for PA and TAP issued. 2 procurement staff in place and remaining are to deputed from CMSD before March 2012. Training to be completed before PA and TAP initiate procurement process. Decision making structure and revision to delegation of power agreed. The report on prior review contracts to be submitted as part of IFR to the Bank.</td>
<td>Substantial</td>
</tr>
<tr>
<td>Non-compliance with agreed procurement arrangements (particularly for decentralized procurement)</td>
<td>High</td>
<td>No decentralized procurement till the capacity is built and a monitoring mechanism is set-up.</td>
<td>Continuous</td>
<td>Low</td>
</tr>
<tr>
<td>External interference (including F&amp;C) in the procurement process</td>
<td>Substantial</td>
<td>Use of a procurement agent. External/internal procurement audits. Use of e-procurement system for NCB/Shopping. Set-up code of ethics.</td>
<td>As above. From year 1. As and when the state is prepared to introduce e-GP. Code of ethics to be signed by each of the procurement staff before March 31, 2012.</td>
<td>Moderate</td>
</tr>
</tbody>
</table>
50. Methods of Procurement: The Table 2 given below gives highlight of the various procurement methods to be used for this project. These along with agreed thresholds would be reproduced in the procurement plan. The thresholds indicated in the following table is for the initial 18 months period and is based on the procurement performance of the project, these thresholds would be modified as and when required. Domestic preference will be applicable for ICB procurement of Goods and Works as per Appendix 2 of the Procurement Guidelines.

Table 2: Procurement Methods

<table>
<thead>
<tr>
<th>Category</th>
<th>Method of Procurement</th>
<th>Threshold (US$ Equivalent)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Goods and Non-consultant services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ICB</td>
<td>&gt;1,000,000</td>
<td></td>
</tr>
<tr>
<td>LIB</td>
<td>wherever agreed by Bank</td>
<td></td>
</tr>
<tr>
<td>NCB</td>
<td>Up to 1,000,000 (with NCB conditions)</td>
<td></td>
</tr>
<tr>
<td>Shopping</td>
<td>Up to 50,000</td>
<td></td>
</tr>
<tr>
<td>DC</td>
<td>As per para 3.7 of Guidelines</td>
<td></td>
</tr>
<tr>
<td>PPP Services</td>
<td>As per para 3.14 of Guidelines</td>
<td></td>
</tr>
<tr>
<td>Force Account</td>
<td>As per para 3.9 of Guidelines</td>
<td></td>
</tr>
<tr>
<td>Framework Agreements</td>
<td>As per para 3.6 of Guidelines</td>
<td></td>
</tr>
<tr>
<td>Procurement from UN Agencies</td>
<td>As per para 3.10 of Guidelines</td>
<td></td>
</tr>
<tr>
<td>Performance Based Procurement</td>
<td>As per para 3.16 of Guidelines</td>
<td></td>
</tr>
<tr>
<td><strong>Works</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ICB</td>
<td>&gt;15,000,000</td>
<td></td>
</tr>
<tr>
<td>NCB</td>
<td>Up to 15,000,000 (with NCB conditions)</td>
<td></td>
</tr>
<tr>
<td>Shopping</td>
<td>Up to 50,000</td>
<td></td>
</tr>
<tr>
<td>DC</td>
<td>As per para 3.7 of Guidelines</td>
<td></td>
</tr>
<tr>
<td>Force Account</td>
<td>As per para 3.9 of Guidelines</td>
<td></td>
</tr>
<tr>
<td><strong>Consultants’ Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CQS/LCS</td>
<td>Up to 300,000</td>
<td></td>
</tr>
<tr>
<td>SSS</td>
<td>As per para 3.9-3.11 of Guidelines</td>
<td></td>
</tr>
<tr>
<td>Individuals</td>
<td>As per Section V of Guidelines</td>
<td></td>
</tr>
<tr>
<td>Selection of Particular Types of Consultants</td>
<td>As per para 3.15-3.21 of Guidelines</td>
<td></td>
</tr>
<tr>
<td>QCBS/QBS/FBS</td>
<td>for all other cases</td>
<td></td>
</tr>
<tr>
<td>(i) International shortlist</td>
<td>&gt;500,000</td>
<td></td>
</tr>
<tr>
<td>(ii) Shortlist may comprise national consultants only</td>
<td>Up to 500,000</td>
<td></td>
</tr>
</tbody>
</table>
51. **Review by the Bank: The Bank will prior review following contracts:**

- **Works:** All contracts more than US$10.0 million equivalent;
- **Goods:** All contracts more than US$1.0 million equivalent;
- **Services:** All contracts more than US$1.0 million equivalent;
- **(Other than consultancy)**
  - **Consultancy Services:** > US$500,000 equivalent for firms; and
  > US$200,000 equivalent for individuals

52. **The first two contracts issued by each implementing agency will be subject to prior review irrespective of their value.** In addition, the justifications for all contracts to be issued on LIB, single-source or direct contracting basis will be subject to prior review. In the case of the selection of individuals, the qualifications, experience, terms of reference and terms of employment shall be subject to prior review. These thresholds are for the initial 18 months period and are based on the procurement performance of the project, these thresholds will be modified. The prior review thresholds will also be indicated in the procurement plan. The procurement plan will be subsequently updated annually (or earlier/later, if required) and will reflect the change in prior review thresholds, if any. In addition, the Bank will carry out an annual ex post procurement review of the procurement falling below the prior review threshold mentioned above.

53. **Frequency of Procurement Supervision: The Bank will normally carry out the implementation support mission on semi-annual basis.** The frequency of the mission may be increased or decreased based on the procurement performance of the Project.

54. **Use of Government Institutions and Enterprises:** Government owned enterprises or institutions in India may be hired for unique and exceptional nature if their participation is considered critical to project implementation. In such cases the conditions given in clauses 1.13 of Consultant Guidelines shall be satisfied and each case will be subject to prior review by the Bank. Similarly goods, non-consultancy services or works supplied/carried out by a government-owned unit that is not managerially, legally or financially autonomous shall be considered as a Force Account for which paragraph 3.9 (Force Account) of the Procurement Guidelines will be applicable with prior review of the Bank. This includes the HGIS component, which will be subimplemented by the Remote Sensing Applications Centre (RSAC) under the Department of Science & Technology, Government of U.P along with assistance from the National Remote Sensing Centre (NRSC) of the Indian Space Research Organization, Department of Space, Government of India, who will provide the satellite data and assist wherever needed in the processing of the data for HGIS, as a Force Account unit.

**Environmental and Social (including safeguards)**

**Environment**

**Situation Analysis**

55. The Bank’s first project in the health sector in UP focused primarily on strengthening public sector service delivery at secondary health care facilities and one of the key achievements was introduction of a system for biomedical waste management. A Health Care Waste
Management (HCWM) Plan was developed which served as the basis for implementation and monitoring of activities under the project. Based on a cost-benefit analysis of different options, the GOUP decided to implement HCWM using a turnkey approach by outsourcing procurement, capacity building, transportation and waste treatment and disposal to 9 common treatment facilities operated by private service providers. This was an innovative approach and implementation was ascertained as satisfactory, with scope for improvement. Initial steps were taken to establish institutional mechanisms for coordination, monitoring and reporting, and consultations were held with DOHFW, Pollution Control Board and other stakeholders. The lesson learnt from the earlier project was that requisite systems and an enabling multi-sector institutional environment needed to be put in place for implementation of this cross-cutting component and for sustained monitoring and supervision, along with inter-sectoral coordination and regular capacity building.

56. The UPHSSP will initially support the establishment of an institutional structure – an Environment Management Cell (EMC) – which will coordinate the environment related activities of all departmental health facilities of Medical, Health & Family Welfare across the state. The EMC will be established within DOHFW by issuance of a Government Order and will be funded from state budget resources, including NRHM. The EMC will be responsible for interaction and coordination with the key departments and relevant agencies which are responsible for the provision of utilities, including water and sanitation services and municipal solid waste management in health care facilities across the state. These will include Urban local Bodies, Nagar Nigams, Nagar Palikas, PRIs, Municipalities and water and sanitation authorities. The EMC will also institute and strengthen operational coordination mechanism with the UP State Pollution Control Board, for all aspects of biomedical waste management. To address the requirements and compliance process of private and non-departmental health care facilities, it is recommended that the EMC establish links with the Indian Medical association, Medical Education Department, Nursing Home association, UP Pollution Control Board, Chief Medical Officers, Urban local Bodies, Nagar Nigams, Nagar Palikas etc. As well as the contractual private service providers operating the Common Waste Treatment Facilities.

57. The Structure of EMC at Directorate & Project Support Unit level will be as follows:

a) Directorate level:

<table>
<thead>
<tr>
<th>S.no</th>
<th>Description of Official</th>
<th>No of Post</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Director General or his nominee</td>
<td>1</td>
<td>Additional Charge</td>
</tr>
<tr>
<td>2</td>
<td>Additional Director (Elect)</td>
<td>1</td>
<td>Additional Charge</td>
</tr>
<tr>
<td>3</td>
<td>Joint Director</td>
<td>1</td>
<td>Full time</td>
</tr>
<tr>
<td>4</td>
<td>Hospital &amp; Healthcare management Expert</td>
<td>1</td>
<td>Full time</td>
</tr>
<tr>
<td>5</td>
<td>Biomedical Waste Management Consultant</td>
<td>1</td>
<td>Full time</td>
</tr>
<tr>
<td>6</td>
<td>Assistant Engineer</td>
<td>2</td>
<td>Full time</td>
</tr>
<tr>
<td></td>
<td>Technologist /Assistant Engineer at each CTF unit</td>
<td>10</td>
<td>Additional Charge</td>
</tr>
<tr>
<td>7</td>
<td>Support Staff</td>
<td>4</td>
<td>Full time</td>
</tr>
<tr>
<td>8</td>
<td>A representative of UP Pollution Control Board &amp; IMA &amp; other departments related to this activity</td>
<td>1 each</td>
<td>Special Invitee</td>
</tr>
</tbody>
</table>
b) Project Support Unit level:

<table>
<thead>
<tr>
<th>S.N.</th>
<th>Description of Official</th>
<th>No of Post</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Joint Director/ Coordinator</td>
<td>1</td>
<td>Full Time</td>
</tr>
<tr>
<td>2</td>
<td>Assistant Engineer/ Junior Engineer</td>
<td>1</td>
<td>Full time</td>
</tr>
<tr>
<td>3</td>
<td>Support Staff</td>
<td>2</td>
<td>Full Time</td>
</tr>
</tbody>
</table>

58. It is expected that the EMC will comprise of officials from DOHFW, and deputed officials from other relevant departments (listed above) or on contractual basis. The EMC will report to the Secretary and the Project Director (during project lifetime).

59. The EMC will develop and implement a road map for proper implementation of biomedical waste management and infection control activities as well as other environment related issues as per the regulations of Government of India and guidelines of Central Pollution Control Board. It will be responsible for issuance of instructions and guidelines related to environment management issues, including mercury phase-out, biomedical waste management, water and wastewater management, infection control and sanitation practices, promotion of energy efficient initiatives etc. It will be responsible for the instituting of effective and efficient systems for implementation, procurement, capacity building and monitoring and reporting on environmental management issues related to health care facilities.

60. The EMC will coordinate awareness and training for relevant state agencies and health care facilities and laboratories and general community. This will also include recommending the appropriate institutional structure to be established or strengthened at different levels of state administrations and of health care service delivery. The EMC will also review environmental issues related to construction and up-gradation of health care facilities, including issues related to site selection, design, materials used and construction waste management.

61. Based on a needs assessment, the EMC will develop a road map for proper implementation, monitoring and reporting of biomedical waste management and infection control activities and other environment related issues as per the regulations of Government of India and guidelines of Central Pollution Control Board. An evaluation at end of year 4 will be undertaken to assess effectiveness of the EMC and the appropriateness of the Roadmap. Findings and recommendations will be built into a revised Roadmap for subsequent roll-out across the state.

62. The proposed activities and how the project intends to take this forward has been defined in an Environment Management Plan (EMP), which has been approved by the GOUP and the Bank and disclosed.

Social

63. The Bank’s social safeguards (O.P.4.10 and O.P.4.12) are not triggered as (i) no activities with risks of displacement would be undertaken and (ii) UP has very few tribal people, some of whom were consulted during the Social assessment (SA). As they fall within the pro-poor focus of the project, they are addressed by the Equity Action Plan (EP) and would benefit from the project. The Bank would work closely with the Borrower to develop capacity for implementation of the Equity Plan (e.g., in the Health Knowledge Resource Centre and Data Resource Centre),
and ensure this through regular monitoring. The EP (which has been introduced in section VII and is discussed at length in the Social Assessment Report) is presented below.

<table>
<thead>
<tr>
<th>Equity Action</th>
<th>How</th>
<th>Responsibility</th>
<th>When</th>
<th>Monitoring</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conduct studies that assist the programme to improve access and quality of health care to people who are underserved and who face social or economic barriers to improving their health outcomes</td>
<td>PSU will prepare the TORs for an agency to be contracted (by the TA provider) to carry out the studies. At least four high quality equity-related studies would be completed during the project period.</td>
<td>Project Support Officer in charge of Equity Plan together with officer in charge of Strategic Planning (if different)</td>
<td>Studies would be identified on an on-going basis, and completed according to the time schedule specified in their TORs.</td>
<td>(i) TORs prepared (ii) Studies completed on time.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sub-components on Strengthening Data Development and Use for Decision-making, and Health Geographic Information System</th>
<th>Development and Use for Decision-making, and Health Geographic Information System</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ensure that health data are disaggregated by geographic, social and economic variables and analyzed accordingly, so that program management decisions are made with a focus on equity and reducing disparities in access to health care</td>
<td>The relevant variables will be identified and incorporated in the design of the health data systems. Reports from these systems and other data sources analyzing socio-economic disparities will be generated for use by program managers and decision makers. District report cards would include equity variables.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sub-component on Social and Provider Accountability</th>
<th>Development and Use for Decision-making, and Health Geographic Information System</th>
</tr>
</thead>
<tbody>
<tr>
<td>Develop and pilot social mechanisms</td>
<td>Conduct a study of previous</td>
</tr>
<tr>
<td>to improve service provision and health behaviors, particularly among economically, socially and geographically vulnerable people</td>
<td>efforts, design 3-4 possible pilots, and pilot them in different areas of UP at a significant scale. Assess their progress and results within the project period, and report to policy-makers for scaling-up.</td>
</tr>
</tbody>
</table>
### Project Stakeholder Risks

<table>
<thead>
<tr>
<th>Description</th>
<th>Rating</th>
<th>Risk Management</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>This project has been under discussion with GOUP for several years. There have been numerous changes in leadership in the health sector in UP.</td>
<td>High</td>
<td>An ongoing dialogue on the project has been maintained with GOUP stakeholders in the health sector as well as among other sectors.</td>
<td>Not yet due</td>
</tr>
</tbody>
</table>

### Implementing Agency Risks (including fiduciary)

<table>
<thead>
<tr>
<th>Description</th>
<th>Rating</th>
<th>Risk Management</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Institutional capacity and human resource constraints continue to affect efficient service delivery</td>
<td>High</td>
<td>1. The project addresses human resource constraints relevant to clinical, public health and program management cadres. The project design and implementation structure will provide continuity and Technical Assistance support that will mitigate against capacity constraints and staff changes.</td>
<td>Not yet Due</td>
</tr>
<tr>
<td>2. Weak processes and systems (e.g. M&amp;E, quality supervision, inflexibility, bureaucracy, etc.).</td>
<td></td>
<td>2. The project will provide support to strengthen these processes and systems.</td>
<td></td>
</tr>
<tr>
<td>3. Project accounting locations may not receive adequate resources on time.</td>
<td></td>
<td>3. Approval of budget and timely allocation of resources to expenditure making locations; this will be constantly monitored.</td>
<td></td>
</tr>
<tr>
<td>4. Inadequate internal controls such as weak record keeping, payments under single signature and non-responsiveness on recurring audit observations.</td>
<td></td>
<td>4. Project guided by State Financial Handbooks and Manuals; all payments through treasuries which are independent of the DOHFW; regular Internal Audit, which will be entrusted to a firm of Chartered Accountants.</td>
<td></td>
</tr>
</tbody>
</table>
5. Weak capacity for handling procurement may result in delays, higher prices and non-compliance with agreed procurement arrangements. External influences in procurement process and instances of F&C are risks. **Risk Management:**

5. The Procurement Manual, Bidding Documents and RFPs for the first 12 months have been prepared. Procurement training has been provided to two procurement experts in the Project Support Unit (PSU). The third party Procurement Agent will be responsible for handling procurement of goods/non-consulting services, for skill transfers to the Central Medical Stores Department (CMSD) as well as procurement capacity building in CMSD and at the decentralized level. Decentralized procurement will not be allowed until sufficient capacity is built and a monitoring mechanism is set up. In addition there will be 6 monthly internal and annual external audits to review procurement process; disclosure on the project website; improved complaint handling and a code of ethics for procurement staff.

<table>
<thead>
<tr>
<th>Governance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Description:</strong> The accountability mechanisms in the Department of Medical Health and Family Welfare, UP, are very weak. In particular there is a lack of appropriate human resource management systems, transparent procurement systems, and personnel training on rights and obligations in answering RTI-related enquiries. There are major obstacles to merit-based personnel management and effective and transparent procurement.</td>
</tr>
<tr>
<td><strong>Risk Management:</strong> While many of these issues may not be under the direct control of the project, project support to both human resources and procurement, along with other improved systems, would be designed to move the sector into a direction of improved governance. Within the Department of Health, measures to address governance problems will include: clear delineation of roles, delegation of decision making and financial authorizations among the department, PSU and PCT; creation of an internal system of vigilance; public disclosure of project information and support for systematizing information disclosure under the RTI Act through the Department of Health</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Project Risks</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Description:</strong> The institutional capacity and management systems of the Health Directorate are “the weak middle”, representing major challenges to improved service delivery. The project will require the development of additional specialist support cells located within the Directorate of Medical Health.</td>
</tr>
<tr>
<td><strong>Risk Management:</strong> The project is designed to enable better delivery of health services through developing and improving institutional resources and systems. Specialist support cells located within the Directorate of Medical Health will support institutional strengthening, and will be responsible for implementing and managing activities supported under the project</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Resp: Client</th>
<th>Stage: Prep</th>
<th>Due Date: 06/30/2012</th>
<th>Status: Not yet Due</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Resp: Client</th>
<th>Stage: Prep</th>
<th>Due Date: 06/30/2012</th>
<th>Status: Not yet Due</th>
</tr>
</thead>
</table>
## Social & Environmental Rating: Moderate

### Description:
1. The project will support the establishment of a state-level policy and institutional framework for infection control and waste management practices as required by the national regulation. Poor implementation and insufficient monitoring and enforcement by the Department of Health may result in non-compliance of individual facilities with the GOI’s national policy.

2. The key social risk is that the project will fail to develop adequate strategies and mechanisms to reach those most in need of health care and will not be able to improve equity in access to health care nor in health outcomes.

### Risk Management:
1. An Environment Management Plan will be prepared by the client, defining a roadmap to include required institutional, implementation and monitoring components, as well as environmental mitigation measures for implementation at the service delivery level.

   - **Resp:** Client  
   - **Stage:** Prep  
   - **Due Date:** 05/02/2012  
   - **Status:** Not yet Due

2. The social accountability component under component 2 aims to improve both health service provision and household health behaviors in order to enhance equity in health. This includes village level and block level social group-wise segregated services user information.

### Program & Donor Rating: Low

### Description:
Priorities of different national programs, NRHM, RCH II, RNTCP II, NVBCDP and other donors will put competing demands on leadership and technical staff.

### Risk Management:
The Project design was finalized on the basis of consultations with the national level and by engaging donors at the national and state levels. This project would complement and explore synergies with other national and donor programs.

### Delivery Monitoring & Sustainability Rating: Substantial

### Description:
Sustainability of a high level of implementation/technical support and stewardship for systems strengthening is a potential risk in the long term.

### Risk Management:
Building sufficient capacity in the project support unit, as well as at the directorate level and ensuring appropriate Procurement & Technical Assistance support will increase the sustainability of the project.
<table>
<thead>
<tr>
<th>Overall Risk Following Review</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implementation Risk Rating: Substantial</td>
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</table>

**Comment:**
The overall ratings for preparation and implementation reflect the risks stated above. The team has discussed the mitigation measures with the UP government and has full assurances that these will be implemented in full and in a timely manner. Project preparations by the existing PMU are within the agreed timelines and all the readiness filters have been met at this stage.
Annex 5: Implementation Support Plan

INDIA: UTTAR PRADESH HEALTH SYSTEMS STRENGTHENING PROJECT

1. The implementation support plan for the project has been developed based on the specific nature of the project activities, lessons learned from past operations in the country and sector, and the project’s risk profile in accordance with the Operational Risk Assessment Framework (ORAF). The plan will be reviewed once a year to ensure that it continues to meet the implementation support needs of the project.

2. Strategy and approach for implementation support: The implementation support strategy is based on the combination of several mechanisms that will enable enhanced implementation support to the GOUP and timely and effective monitoring. The mechanisms to be employed comprise: (a) intensive supervision and hand holding in the first year, given the range of implementing departments/directorates and their limited capacities, (b) regular technical meetings and field visits by the Bank, (c) the Health Department and PCT reporting based on internal monitoring, (d) independent third party monitoring/validation, and (e) internal audit, procurement and FM reporting. Information from various sources will be used to assess and monitor progress of the project throughout its implementation. In addition, the progress on the GAAP will be reviewed every six months as part of the implementation support missions. Most information would be collected through the state’s system and the remaining information will be collected either directly by PCT or validation of data using data triangulation or by a third party source would be used wherever quality of reporting is poor. Verification of the DLI results would be done using third party validation. Data would be collected through routine MIS, provider surveys, patient satisfaction and feedback surveys, facility based quality assessments, evaluations and community monitoring.

3. The first year of the implementation will be critical in ensuring that project staff resources and technical capacity are in place to improve organizational performance and enable the delivery of better health outcomes. The focus in the first year will need to be on the following issues: setting up a data resource centre; establishing personnel information systems; establishment of the strategic health and knowledge centre; introducing social accountability action research; setting up mechanisms to improve provider accountability; establishing three cells in the Health Directorate, namely, Environmental Management, PPP, and Quality Assurance; appointment of a chartered accountant for internal audit; a study on consolidating financial information through a “dashboard” and the appointment of a procurement agent and third party TA provider.

4. The Bank FM, procurement, social and environmental specialists, who are based in the country office will play a vital role in successful project implementation support, given that the project includes capacity building in these areas for the Department/Directorate, hospitals, and/or communities. These Bank specialists, in collaboration with Task Team Leader and team, are expected to provide timely, effective, and intensive support to the client.

5. Implementation Support Plan: During the first year, the project will have semi-annual implementation support missions, including field visits. The semi-annual missions will focus on review of the project performance against results framework, progress towards DLI targets and agreement on planned actions as well as progress made on the GAAP. The scope of the
implementation support mission will also include monitoring the GOUP’s compliance with stipulated FM, procurement, and safeguards guidelines. One month prior to the formal review mission, PSU will provide to the Bank a comprehensive progress report on project activities. In addition to the formal missions, several technical missions to Lucknow by the Bank team from the New Delhi Office will be carried out to accelerate implementation. The Bank team will monitor institutional strengthening interventions and the operationalization of support units and resource centers. To ensure a high quality and comprehensiveness of support in light of the project design, the Bank team will comprise not only health specialists and economists but also specialists in FM, procurement, safeguards, and governance and accountability, with the specific team composition for each mission determined based on the requirements at that time.

6. The first implementation support mission will take place in January 2012, if GOUP agrees, with a midterm review in June 2014 and project closure in March 2017. The main focus of implementation support is described below. In light of the complexity of the project design, the estimated annual resources required for effective implementation support will be substantial, though it will be discussed and agreed with the sector unit and country management unit.

<table>
<thead>
<tr>
<th>Focus</th>
<th>Skills Needed</th>
<th>Resource Estimate</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td>First 12 months</td>
</tr>
<tr>
<td>Team leadership and coordination</td>
<td>Task Team Leader</td>
<td>9 SWs</td>
</tr>
<tr>
<td>Technical Reviews and support,</td>
<td>Health Specialists, Economist</td>
<td>12 SWs</td>
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<tr>
<td>including data analysis and health</td>
<td></td>
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<tr>
<td>systems</td>
<td></td>
<td></td>
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<tr>
<td>Institutional arrangement and</td>
<td>Operations Specialist</td>
<td>6 SWs</td>
</tr>
<tr>
<td>GAAP</td>
<td></td>
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<tr>
<td>FM training and review</td>
<td>FM Specialist</td>
<td>8 SWs</td>
</tr>
<tr>
<td>Procurement training and review</td>
<td>Procurement Specialist</td>
<td>8 SWs</td>
</tr>
<tr>
<td>Social accountability pilot start-up</td>
<td>Social Specialist</td>
<td>6 SWs</td>
</tr>
<tr>
<td>EM Cell and CTF evaluation</td>
<td>Environmental Specialist</td>
<td>6 SWs</td>
</tr>
</tbody>
</table>

Note: SW = staff week
Annex 6: Team Composition

INDIA: UTTAR PRADESH HEALTH SYSTEMS STRENGTHENING PROJECT

<table>
<thead>
<tr>
<th>Name</th>
<th>Designation</th>
<th>Division</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vikram Rajan</td>
<td>Task Team Leader, Senior Health Specialist</td>
<td>SASHN</td>
</tr>
<tr>
<td>Gerard Martin La Forgia</td>
<td>Lead Health Specialist</td>
<td>SASHN</td>
</tr>
<tr>
<td>Preeti Kudesia</td>
<td>Senior Public Health Specialist</td>
<td>SASHN</td>
</tr>
<tr>
<td>Will Starbuck</td>
<td>Senior Operations Officer</td>
<td>SASHN</td>
</tr>
<tr>
<td>Henri A Aka</td>
<td>Operations Officer</td>
<td>SASHN</td>
</tr>
<tr>
<td>Naoko Ohno</td>
<td>Operations Officer</td>
<td>SASHN</td>
</tr>
<tr>
<td>Rajeev Ahuja</td>
<td>Health Economist</td>
<td>SASHN</td>
</tr>
<tr>
<td>Onika Vig</td>
<td>Team Assistant</td>
<td>SASHD</td>
</tr>
<tr>
<td>Shafali Rajora</td>
<td>Team Assistant</td>
<td>SASHD</td>
</tr>
<tr>
<td>Meera Chatterjee</td>
<td>Senior Social Development Specialist</td>
<td>SASDS</td>
</tr>
<tr>
<td>Shanker Lal</td>
<td>Senior Procurement Specialist</td>
<td>SARPS</td>
</tr>
<tr>
<td>Tanuj Mathur</td>
<td>Senior Financial Management Specialist</td>
<td>SARFM</td>
</tr>
<tr>
<td>Ruma Tavorath</td>
<td>Senior Environment Specialist</td>
<td>SASDI</td>
</tr>
<tr>
<td>Juan Carlos Alvarez</td>
<td>Senior Counsel</td>
<td>LEGES</td>
</tr>
<tr>
<td>Vikram Chand</td>
<td>Peer Reviewer, Senior Public Sector Management Specialist</td>
<td>SASGP</td>
</tr>
<tr>
<td>Vikram Menon</td>
<td>Peer Reviewer, Senior Public Sector Specialist</td>
<td>SASGP</td>
</tr>
<tr>
<td>Peter Berman</td>
<td>Peer Reviewer, Lead Health Economist</td>
<td>HDNHE</td>
</tr>
<tr>
<td>Patricio V. Marquez</td>
<td>Peer Reviewer, Lead Health Specialist</td>
<td>ECA</td>
</tr>
<tr>
<td>Finn Schleimann</td>
<td>Peer Reviewer, Senior Health Specialist</td>
<td>HDNHE</td>
</tr>
<tr>
<td>G. N. V. Ramana</td>
<td>Peer Reviewer, Lead Health Specialist</td>
<td>AFTHE</td>
</tr>
<tr>
<td>Akiko Maeda</td>
<td>Peer Reviewer (QER), Lead Health Specialist</td>
<td>HDHNE</td>
</tr>
<tr>
<td>Ram Chopra</td>
<td>Peer Reviewer (QER), Lead Health Specialist</td>
<td>HDHNE</td>
</tr>
<tr>
<td>April Harding</td>
<td>Peer Reviewer (QER), Senior Health Economist</td>
<td>HDHNE</td>
</tr>
<tr>
<td>Marcelo Bortman</td>
<td>Peer Reviewer (QER), Senior Health Specialist</td>
<td>ECSH1</td>
</tr>
<tr>
<td>Arun Manuja</td>
<td>Peer Reviewer (QER), Senior FM Specialist</td>
<td>SARFM</td>
</tr>
</tbody>
</table>
INDIA: Second Uttar Pradesh Health Systems Strengthening Project (UPHSSP)

Background

1. The need for a Governance and Accountability Action Plan (GAAP) is based on the recognition by the State Government of Uttar Pradesh and the World Bank that there are institutional weaknesses, fiduciary, governance and accountability risks in the UPHSSP project, and that specific arrangements must be made to mitigate these risks and to ensure that funds are used effectively and efficiently. The main aim of the GAAP is to ensure that the project development objectives are achieved.

2. Given that weak institutional capacities and systems are key challenges to improve access to quality health care services delivery in Uttar Pradesh, the proposed project represents a departure from the traditional “incremental input for service delivery projects”. It focuses on institutional development, strengthening local systems and accountability, generating demand side accountability, introducing incentives for performance and piloting alternative delivery models, including public private partnership. The UPHSSP will strengthen Uttar Pradesh's Health Department’s capacity to more effectively and accountably manage its human and financial resources, use data for decision making, perform its quality assurance function, and engage the private sector. It will also contribute towards increasing transparency and information flow between the Health Department, hospitals, CHCs and local governments. Through the setting up of a publicly accessible Health Management Information System (HMIS); piloting of awareness raising of HMIS data; institutionalizing the display of Citizen’s Charters and a strengthened and functional grievance redressal system for all 40 hospitals whose accreditation will be supported under the project; through the suo moto disclosure under the RTI Act and training of the Health Department’s RTI officers on their rights and responsibilities; and the appointment of a Vigilance Officer within the Health Department. Some of the risks identified in the ORAF are not under the direct control of the project and the mitigating measures can only be implemented at a State level. A study is being commissioned by the Bank PREM which will examine the political and institutional risks in UP. This study will look at cross cutting issues which impact on all projects in UP, as well as risks which relate more specifically to outcomes in the health sector.

3. This GAAP details key actions and mitigating measures to be taken under the project to address risks and strengthen management systems, including financial management, procurement, and environmental management, designed to move the sector into a direction of improved governance, which will improve service levels, access to health care and accountability.

Main Identified Risks

4. The institutional capacity and management systems of the Health Directorate are “the weak middle”, representing major challenges to improved service delivery. Institutional constraints impede service delivery to the entire population, including the poor. Decision-making is highly centralized in the state health authorities and subject to political patronage. Accountability is diffuse between elected officials and local administrators/providers, between elected officials and citizens, and between citizens and local administrators/providers.
Absenteeism, high staff turnover, lack of appropriate training/skills, absence of citizen grievance redressal, and monitoring failures combine to undermine sector performance. Community driven accountability mechanisms for improved service delivery, and community led approaches to improving health promoting and health seeking behavior are limited in the state. Disparate information systems exist and survey data is seldom used to inform planning and budgeting. There is weak capacity in the Department of Health to generate, analyze and use data for decision making.

Mitigation Measures:

5. The approach towards mitigating identified risks involves developing systems to ensure quality service provision to the poorest requires investments in strategic planning, human resources and technical capacity in the state health directorates, and a long term engagement. It also includes strengthening the state government capacity to generate, analyze and use data for informed decision making; focus on the measurement of improvement in organizational performance results rather than service delivery or health outcomes in line with the project design; use state systems with data validation mechanisms to report on progress; and, evaluate outcomes and process of innovative activities and pilots to inform scale up.

Mitigation Measures: Project Design, Institutional Capacity and Management Systems Strengthening

6. Three tier implementation structure. There will be a three-tier structure to shield project implementation from the effects of leadership changes. This will consist of the Project Co-ordination Team (PCT) headed by the Project Director (PD), specialist support cells located within the Directorate of Medical Health and a Project Support Unit (PSU) which will provide dedicated support to the PCT, the specialist support cells and other TA needs of the Directorate and the Department. Specialist support cells located within the Directorate of Medical Health will support institutional strengthening. The support cells will be Quality Assurance, Public Private Partnership, Electronic Data Processing (EDP) Data Resource Centre and Environment Management. These support cells would be responsible for implementing and managing activities supported under the project, related to their respective areas.

7. Quality Assurance (QA). The project will support the establishment and capacity building of a QA Cell in the state directorate to monitor and evaluate the quality of service delivery in the public and private sector, and serve as the technical advisory body to the Directorate for Quality Management Systems in Health. This would involve the rolling out of Continuous Quality Improvement (CQI) programs across hospitals, preparing and enforcing minimum licensing standards and supporting hospitals and other health facilities to get accreditation. The recent introduction in the country of both the National Clinical Establishment Act and National Board of Accreditation of Hospitals (NABH) now provides a framework to develop a set of uniform standards that can be adopted to enable health facilities, both in the public and private sectors, to deliver quality health services. This will require the improvement in the quality of service delivery at public sector hospitals to enable accreditation under the National Accreditation Board of Hospitals (NABH). The accreditation of health facilities will benefit the poor as the quality improvements that come with accreditation require defining standard operating procedures, from the entry of patients into the hospital until their discharge/referral and follow-up. This will ensure that the quality of care remains the same irrespective of the socio-economic background of the patient.
8. **Clear delineation of roles, delegation of decision making and financial authorizations.** Details and clarifications on the roles and responsibilities of the PCT, Department of Health and Family Welfare and the PSU and their relationships, will be provided through a Government Order.

**Mitigation Measures: Accountability and Transparency**

9. **Accountability and transparency.** The improved use of data for program management in collaboration with the existing Electronic Data Processing (EDP) Cell in the Department and the expansion of its scope to function as a Data Resource Center. Data will be collected at each level and utilized for the improved management of health programs, the improvement of service delivery quality and health outcomes, focusing on equity and reducing disparities in access to health care. Institutional data will be linked to community, clinical and epidemiological information. The focus will be on a two pronged approach; strengthening the EDP Cell to function as a Data Resource Centre (DRC) to enable better use of data for program management, and strengthening ongoing systems such as the personnel information systems (PIS) to make them into systems designed for transparent decisions related to human resource management.

10. The proposed project will develop, pilot and evaluate model/s for community assessment of health and health care at the local level and use the assessment information to stimulate community action to demand better services enhance positive health behaviors and community actions that improve health, and promote community audits of service delivery and drug and human resource availability. These models would be geared to improving equity in health and access to and the utilization of health care. Equity in access and public sharing of equity in access will be enhanced through the registration system and web-based data dissemination system. The registration system at facilities will include the patient’s village, block, gender and BPL/non BPL status. Data detailing hospital reporting will be made publically accessible through the Health Department website.

11. **Systematic district-level data reporting for informed decision-making.** The project will support systematic a district level reporting of information on health outcomes, primary care service coverage and health facility performance (production, productivity, quality, and equity) to facilitate regular monitoring at district level. Based on this reporting, district-level reports will be generated annually through DRC and disseminated through the department’s website. This will improve accountability and transparency as well as inform health management decisions. The DRC program reports will be validated through independent validation techniques, including sample surveys.

12. **The Right to Information Act.** Currently there are twenty designated Right to Information (RTI) officers within the Health Directorate. In addition, there are designated RTI officers at the district hospital levels. The Chief Medical Officers (CMO) or their nominees are also designated as RTI officers. However, the public disclosure of information set out by the RTI Act is weak at the departmental level. This project will facilitate public disclosure of all the information mandated under the RTI Act within the Health Department. A project website will be used for information disclosure and dissemination, on all aspects of the project. Relevant information will also be available in the state language. The project will ensure proactive disclosure and sharing of information with key stakeholders, including communities and...
beneficiaries. In addition the designated RTI officers will be trained on their roles and responsibilities under the Act.

13. **Grievance redressal.** The purpose of a robust and responsive grievance redressal is to ensure that any query or complaint with regard to any aspect of project implementation is heard and promptly addressed. The development of an integrated system will enable the seamless integration of feedback from the public and the effective handling of complaints. Furthermore, a grievance redressal mechanism will be designed and institutionalized for all hospitals enrolled under the accreditation program.

14. **Vigilance function.** At the state level, there is no legal requirement for a vigilance function at the department level. Currently there is a state-wide vigilance establishment. In addition, three departments have an internal vigilance officer. Though not mandated, the Health Department is keen on establishing an internal vigilance system and nominating a vigilance officer for better internal oversight.

*Mitigation Measures: Procurement, Contract Management & Financial Management*

15. **Financial Management (FM).** With use of the mainstream GOUP systems, financial management will be guided by State Financial Handbooks and Budget Manual. These documents lay down the policies and procedures for the entire FM cycle from budgeting to accounting/internal controls and also prescribe formats for reporting and record keeping. Secondly, internal controls will be strengthened through the role of UP Treasuries (which works under the Finance Department) which will review, check compliance and then approve all payments. Also a process for Internal Audit has been established. Thirdly, Statutory Audit will be conducted by the CAG as per a Terms of Reference agreed with the Bank for all projects in India. Further, a Project Financial Management Manual (FMM), has been prepared which refers to the relevant state rules and provides guidance on budgeting, fund authorization, internal controls, accounting, reporting and audit arrangements.

16. **Procurement Agent (PA) and the Technical Assistance Provider (TAP)** A PA will be contracted to carry out the procurement of hospital equipment, furniture, vehicles, hospital and office supplies and non-consulting services for the project. This PA would also be responsible for skill transfers to Central Medical Stores Department (CMSD) as well as procurement capacity building in CMSD. The TAP will provide TA consultancy support as well as contract external TA as required. No decentralized procurement is envisaged under the Project. PA and TAP will also help the PSU in contract management.

*Performance Indicators*

17. The GAAP will be monitored based on the following performance indicators:

- The quality and timeliness of voluntary disclosure of public information and of grievance redress by relevant agencies; and
- Completion of studies and improvements in data collection, analysis and reporting focusing on identifying exclusion and appropriate strategies for vulnerable groups.
- Adherence to time lines in the GAAP.
<table>
<thead>
<tr>
<th>Risk description</th>
<th>Mitigation steps</th>
<th>Responsibility</th>
<th>Timeline/status</th>
</tr>
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</table>
| Institutional: Vulnerability due to frequent changes in project leadership and staff, leading to the loss of institutional knowledge and sustainability of the project. | - The design of this project uses a 3 tier implementation structure consisting of a Project Coordination Team (PCT), led by the Project Director (PD), who will be supported by an Additional Project Director. The PCT team will also have members drawn from the DOMH&FW and their respective Directorates. This will ensure continuity in the case of key staff changes and the ownership and active involvement of the concerned departments.  
  - Specialist support cells embedded within the directorates will be responsible for implementing and managing activities supported under the project, ensuring that capacity is built within the directorate. The reporting line for these cells will be to the Director General Medical and Health ensuring ownership by the department and independence from the PCT.  
  - The Project Support Unit (PSU), in addition to supporting the PD and the PCT will contract and supervise the third party Procurement Agent and Technical Assistance Provider (TAP). In addition the PSU will ensure that the project’s institutional memory and continuity of support is maintained throughout any key staff changes.  
  - Technical specialists provided by the third party TA provider (TAP) will ensure continuity and timely provision of technical capacity building and assistance. | Project Director (PD) supported by the Additional PD, the Project Coordination team and PSU | PCT, PSU in place by January, 2012     |
<p>| Weak technical capacity of staff in the Directorate of Medical Welfare to implement health sector reform and systems strengthening | - Hiring of a third party TAP by PSU to provide timely technical assistance and consultancy support to the specialist support cells in the directorate to ensure that the project’s various sector reform activities and areas for strengthening are supported. | PCT, PSU, GOUP                           | Contract signed with TAP by June, 2012   |</p>
<table>
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<tr>
<th><strong>Weak public health sector management functions</strong> in strategic planning, budgeting, monitoring, impede improved service delivery and the efficient utilization of available financing and resources for the sector</th>
<th>• Component 1 is strongly focused on strengthening the strategic planning functions in the Health Department, working closely with the recently established HKRC in the DOFW; improving the use of data for program management in collaboration with the existing Electronic Data Processing (EDP) Cell, which will be expanded to function as a Data Resource Centre. Additional support for these management functions will be provided by the project through the establishment of specialist cells in the Directorate.</th>
<th>PCT, Directorate of Medical Health &amp; its specialist support cells, PSU, Goup, and TAP</th>
<th>Specialist cells established by September 30, 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Weak regulatory systems:</strong> The lack of a standard framework and procedures and poor monitoring, as well as the absence of Continuous Quality Improvement Programs result in poor quality services being produced.</td>
<td>• Under component 2, the institutional capacity for ensuring service quality and regulation will include the establishment and capacity building of Quality Assurance (QA), Environment Management (EM) and Public Private Partnership (PPP) cells in the Directorate of Health. This will enable the Health Dept and Directorates to introduce QA mechanisms in support of the recently introduced National Clinical Establishment Act, strengthen healthcare waste management, as well as manage and monitor performance based contracts as well as PPPs. The QA cell will be responsible for monitoring the accreditation process of selected public hospitals, to enable the improvement in the quality of their service delivery.</td>
<td>PCT, Directorate of Medical Health QA Cell, TAP</td>
<td>Establishment of QA, PPP and EM Cells by September 30, 2012. QA Cell has already been established by the GOUP by issuing a Government Order. Strengthening of QA cell group will be done by September 30, 2012. PPP Cell will also made functional with help of TAP. EM Cell will be Established by September, 2012.</td>
</tr>
<tr>
<td><strong>Weak institutional “will” and management capacity to develop and use systems for decision making that could improve equity in health service delivery.</strong></td>
<td>• The project supports studies and improvements in data collection, analysis and reporting, focusing on identifying exclusion and appropriate strategies for vulnerable groups. • The Registration System at facilities will include name of the village and block name of each patient and their social category (SC/ST, gender and BPL or not). Disaggregated data will be available on the department’s</td>
<td>PCT, Directorate of Medical and Health, Strategic Planning Cell and Data Resource Centre, TAP</td>
<td>TAP with Strategic Planning Cell and the Data Resource Centre by June 2013. A Strategic Planning Cell has been established and strengthening of the above will be done by December, 2012. The EDP</td>
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</table>
website. VSHC/ Panchayats/ SHGs and the general public will be able to monitor the data. The data will also be used to continuously inform the Equity Plan and the need for informed equity oriented interventions. Cell is already in the department, it will evolve into a Data Resource Centre with the help of TAP by Dec, 2013

<table>
<thead>
<tr>
<th>HR issues: Quality and quantity Institutional capacity and human resource constraints continue to affect efficient service delivery. At present, there are significant vacancies and inadequate positions of different cadres at health facilities in UP</th>
</tr>
</thead>
<tbody>
<tr>
<td>• The Project will provide additional Accreditation Challenge Funds to hospitals which undertake the National Board of Accreditation of Hospitals and Health Care Providers (NABH) accreditation. Facility surveys will identify gaps in service delivery with a needs assessment ensuring that infrastructure funded by GOUP is matched with the necessary equipment, technical support and additional human resources required for the accreditation process being financed from the project. This will enable efficiency and quality gains to be made within the limited resources available.</td>
</tr>
<tr>
<td>• The project will support the creation of a cadre of professional health managers, which should lead to increased administrative efficiencies and better use of limited resources.</td>
</tr>
<tr>
<td>• The TAP will recruit an HR agency to provide necessary staff on a needs basis.</td>
</tr>
<tr>
<td>Directorate of Medical Health Quality Assurance Cell, TAP, PD &amp; GOUP.</td>
</tr>
<tr>
<td>November, 2012</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Weak information environment and difficulty in data driven decision making continues in the Department, due to its inability to generate, analyze and use data for decision making.</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Strengthen the Electronic Data Processing (EDP) cell of the Medical Health Directorate to function as a Data Resource Centre and provide necessary information (what information) to all key stakeholders</td>
</tr>
<tr>
<td>• EDP is already established</td>
</tr>
<tr>
<td>• EDP will be expanded to become the DRC</td>
</tr>
<tr>
<td>• Quality issues with data, data collection needs addressing</td>
</tr>
<tr>
<td>• Will look at doing a short term pilot in 5 districts to demonstrate usefulness. This will need GOUP support, by June 2013.</td>
</tr>
<tr>
<td>PCT, PSU and the EDP/DRC cell, IPD, HMIS, and OPD collects DDC data.</td>
</tr>
<tr>
<td>TAP with EDP cell to complete strengthening plan by December, 2012</td>
</tr>
<tr>
<td>Financial Management: Delays in availability of funds at the project implementing locations impacting project outputs</td>
</tr>
<tr>
<td>---</td>
</tr>
<tr>
<td>Inadequate internal controls like weak record keeping, payments under single signature, and non–responsiveness on recurring audit observations.</td>
</tr>
<tr>
<td>Delayed audits and ineligible expenditure indicating that project FM guidelines have not been adhered to.</td>
</tr>
</tbody>
</table>
| **Procurement:** Delays in procurement decision making due to inefficiencies and inadequate financial and decisions making delegations. These delays result in problems like stock-outs, lower competition (thus increasing possibility of collusion) and increased price. In the predecessor project, non-compliance with agreed procurement arrangements (particularly for decentralized procurement) was also observed, particularly due to weaker procurement capacity. Some instances of influencing the decision-making process by external elements were also noted in non-Bank. | • Delegation of power has been reviewed and is proposed to be revised  
• Use of the procurement agent (PA) and to TA Provider (TAP) with turn-key procurement responsibilities  
• No decentralized procurement till procurement capacity is built at decentralized level and a monitoring mechanism is set-up  
• External/internal procurement audits  
• Use of Code of ethics for procurement staff  
• Use of e-procurement system for NCB/Shopping  
• Disclosure of procurement related information.  
• Appropriate handling of complaints.  
• Realistic cost estimates and qualification requirements.  
• Use of third party and civil society oversight mechanisms. | PD, PSU and CMSD, GOUP (supported by the PA & TAP). | • Contracts of PA and TAP signed by January 31, 2012  
• Capacity building to begin by July, 2012  
• Procurement Auditor appointed by July, 2012  
• Feasibility study for use of e-procurement is completed by December 31, 2012  
• Code of ethics is developed and signed by December 31, 2011  
• A separate section on project website is set-up by December 31, 2011, for the disclosure of procurement related information.  
• Complaint |
<table>
<thead>
<tr>
<th><strong>financed procurement in the state.</strong></th>
<th><strong>handling procedures are developed and agreed with the Bank by July, 2011 (Completed)</strong>&lt;br&gt;• Database of items and suppliers is set-up by July 31, 2012</th>
<th><strong>Accountability and Transparency:</strong>&lt;br&gt;The accountability mechanisms which make health care providers answerable to their clients are weak.&lt;br&gt;• The project supports both social accountability driven and provider incentive pilots to improve provider response to their clients. The TAP will be responsible for developing well designed pilots and evaluation methodology.</th>
<th><strong>PSU, DRC and TAP</strong>&lt;br&gt;Social Accountability and provider incentive pilots designed by March 31, 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• HMIS to be strengthened to include disaggregated data will be made publically accessible through the Health Department website.&lt;br&gt;• Awareness-raising about the HMIS data at the Block / Gram Panchayat/ VHSC levels will be done as part of the social accountability pilots.</td>
<td><strong>DG Medical, PCT, PSU, DRC and TAP</strong>&lt;br&gt;• HMIS tracking is tied in with functionalization of DRC.&lt;br&gt;• Awareness-raising model designed by 30 June, 2013.&lt;br&gt;• Pilots will be initiated in two blocks by January 1, 2014.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• The HMIS data validation pilots will provide a model, which can be scaled up to the state level.</td>
<td><strong>DG Medical</strong>&lt;br&gt;Results from two pilots will be available by June 30, 2014.</td>
<td></td>
</tr>
<tr>
<td><strong>Data Reporting:</strong> Currently there is no systematic and reliable district-level data reporting.</td>
<td>• District-level report cards, focused on production/productivity, quality and equity will be generated annually through the HMIS.</td>
<td><strong>DRC, PCT; Directorates of MH&amp;FW (Data Resource Centre)</strong>&lt;br&gt;25% of district report cards completed and published with indicators on health outcomes, service coverage and facility performance by March 2015 and 75% by March 2016.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• RTI officers in the Health Department will be trained on the RTI Act and their roles and responsibilities.&lt;br&gt;• The Health Department will</td>
<td><strong>DG Medical/ Directorate/ PSU/PCT/TAP</strong>&lt;br&gt;• RTI training for Public Information Officers (PIOs) to be organized by 31 January 2013</td>
<td></td>
</tr>
<tr>
<td><strong>Grievance Redressal:</strong></td>
<td><strong>Vigilance Function:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>--------------------------</td>
<td>-------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>There is no systematic grievance redressal system at the Health Department or hospital level.</td>
<td>There is no legal requirement for a vigilance function at the department level.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- The grievance redressal mechanism will be designed and institutionalized for all 40 hospitals.</td>
<td>- A Vigilance Officer will be designated and made functional in the Health Department.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- The grievance redressal cell will be established at 25% of the facilities by June 30, 2013.</td>
<td>- The Vigilance Officer will be trained and provided necessary infrastructure to function effectively.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>DG and PCT</strong></td>
<td><strong>DG/ Directorate</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The grievance redressal cell will be established at 100% of the facilities January 1, 2014.</td>
<td>June 30, 2012</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Annex 8: Economic and Financial Analysis

INDIA: UTTAR PRADESH HEALTH SYSTEMS STRENGTHENING PROJECT

ECONOMIC ANALYSIS

I. A brief overview

1. Uttar Pradesh (UP) is the most populous Indian state and is also one of the poorest states. The share of its population below the poverty line (32.8%) has remained constant since 2004-05. Agriculture is still the mainstay for the majority of the population in UP. Although it contributes only around 32% to the state domestic product, the sector generates about 66% of employment in the state. The state is also politically important with 15% of the elected membership to lower house of the parliament (Lok Sabha) allocated to UP.

2. The state has made substantial progress in the recent years in some socio-economic indicators. For example, female literacy rate in the state has gone up from 42.2% in 2001 to 59.3% in 2011 (the corresponding increase at the national level has been from 53.7% to 65.5%); and sex ratio has gone up from 897 in 2001 to 908 in 2011 (corresponding increase at national level has been from 933 to 940). However, these state averages mask the considerable variation in socio-economic indicators that exists across different regions and across various population sub-groups in the state. For example, the poverty rate in the Central and Eastern regions is 10 to 20 percentage points higher than in the Western region. The state experienced robust economic growth, real Gross State Domestic Product (GSDP) growing on average by 6.5% per annum between 2003-04 and 2009-10.

II. Health overview

3. The state has made significant improvements in health indicators in the recent years, particularly after the launch of NRHM in 2005-06 as already outlined in sections IA and IB. For example, the percentage of mothers who received any ante-natal check-up in the state increased from 57 in 2002-04 to 64.4 in 2007-08 (the increase at national level has been 73.6 to 75.2 corresponding to the same period). Even though the state has made significant gains on health indicators, the state remains lagging behind the national averages. The same holds for public health care financing that has been rising in the past few years. Increased public funding to the health sector (a sector that was substantially fund-constrained in the past), led to some quick initial gains in health indicators (see financial analysis below). Notwithstanding this increase, the level of public health spending remains quite low.

4. Health equity goals have been poorly served in UP: The impoverishing effects of health care expenditures have been significant in the state: 8% of total households in UP fell below the poverty line due to health care expenditures in 2004 (compared to 6.2% the national average). 1.1 percent of households fell below poverty line due to inpatient care and 6.9 percent due to outpatient care. The impoverishment effect is greater in rural areas (1.2 for

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45 One of the poverty estimates (the one on the lower side) for UP is 32.8% in 2004-05 as per the Press Note on Poverty Estimates, Planning Commission, Government of India, January 2011.
inpatient care and 7.5 for outpatient care) than in urban areas (1.1 and 6.9 respectively). Not only is the utilization of health services low in public sector\textsuperscript{46} that tends to provide financial protection but also there is a huge variation, both between urban and rural areas of UP and between the poor and the non-poor. For example, share of children completely immunized in rural areas of the state is only 21\% while this share is 33\% in urban areas. The full immunization rate is 15.3\% among the poor while the same is 43\% among the non-poor population of the state\textsuperscript{47}.

III. About the project

5. Post-NRHM, the public health system in UP is no longer as fund constrained as it used to be. The current challenge facing the UP health system is in translating funds into health services as is amply borne about by low utilization of available funding. In the presence of bottlenecks of key complementary inputs (e.g. human resource such as nurses and specialists, laboratory services and so forth) and weak public sector management functions, the state cannot make significant advances in health outcomes. Removing these bottlenecks by leveraging the resources of the private sector wherever it exists and improving public sector management functions is the main strategy of this project.\textsuperscript{48} In order to achieve these, the project interventions must operate on several fronts and complement the NRHM program.

6. Project interventions can be grouped into two broad themes:\textsuperscript{49} one, aimed at addressing institutional constraints by improving public sector management functions (e.g., strengthening financial management systems, procurement and supply chain management systems, strengthening incentives and accountability mechanisms, improved use of data for program management, contracting private sector for diagnostic services and so forth), and the other aimed at building government capacity to perform its stewardship role in the health sector, as well as strengthening policy making by generating information/evidence that can both guide government in prioritization of its policies/decisions and better allocation of its resources (e.g., strengthening strategic planning function, strengthening capacity for service quality improvement in both public and private sector and supporting environment management regulation and so forth).\textsuperscript{50} See Annex 2 for details of the interventions. However, we justify below the rationale for Bank supporting such activities in each of the two broad categories.

\textsuperscript{46} The utilization of public facilities has been quite low in the state. For example, only 27\% (against the national average of 42\%) of all hospitalized cases in rural areas and 31.4\% (against the national average of 38.2\%) of all such cases in urban areas were treated in public facilities in 2004.
\textsuperscript{47} 2005-06: National Family Health Survey 3 (NFHS 3)
\textsuperscript{48} In order to enable the state, that is known for its weak public sector management functions, to leverage the strengths of private sector, the project aims to build the necessary capacities in the state for contracting and regulation of the private sector.
\textsuperscript{49} The categorization used for this purpose is not the same as that of the project components but project interventions remain the same.
\textsuperscript{50} However, certain other interventions such as strengthening PPP capacity of the health department, gap filling in public hospitals that is necessary for them to get accredited could overlap both the categories.
A. Stewardship, strategic planning and prioritization

7. Given the huge scale and diversity of private sector in health care provision, the stewardship of the overall health sector is important for achieving broader health objectives of better health outcomes, financial protection and patient satisfaction. However, lack of information, weak capacity and a failure to set a high priority for the stewardship function have acted as the key constraints to government playing this role in the health sector in UP.

8. The functions of stewardship and planning/prioritization are central to the role of government especially when (a) the state has almost neglected these functions in the past, and (b) the state is spending significant and increasing levels of public resources in the health sector. The need for a strategic planning and policy unit in the health sector has never been as strong and compelling as it is now. When the quantum of resources flowing into the health sector was limited with little flexibility to shifting those limited funds, the scope for strategically redirecting those resources was circumscribed. Furthermore, with the limited public funds distributed too thinly across the vast geographical area and on diverse set of activities, the scope for improving technical efficiency of the limited resources deployed too was restricted. But the context has changed post-NRHM. The flow of funds has increased not only from the central government but also the state government itself (public health spending has increased on average by 25% per annum in real terms from 2005-06 to 2009-10). There is a need to direct the increasing flow of resources to areas consistent with government priorities and to base these priorities on evidence. Expanding the evidence base would help the state in performing better its stewardship role in the health sector and also provide the basis for strengthening the public sector health system. Even if a third of the project’s annual financial assistance of US$34 million (the project provides US$170 million for 5 years) is invested in stewardship and strategic planning interventions, this investment (of about US$11 million) would be really worthwhile to guide the state’s annual health budget of US$2 billion.

B. Strengthening public sector management functions

9. With the easing of the funding constraint, other constraints have become binding. The government has taken note of these, and is now according high priority to resolving these constraints. The evidence for other binding constraints is reflected in the state not able to fully absorb available funds. A good example of this is utilization rate of NRHM flexi pool. Even though the NRHM flexi pool represents only 26% of all NRHM allocations, it reflects the state’s capacity to absorb additional resources as it funds mostly new activities. The figure below shows that cumulatively the utilization rate from 2005-06 to 2009-10 has been only 60%, that is, only 60% of allocated resources under NRHM flexi pool have been utilized, though this situation has improved in 2010-11. Due to poor utilization, resource allocation under NRHM flexi pool has fluctuated widely between 2005-06 and 2010-11 and actually declined in 2008-09, and was only marginally higher in 2009-10 as compared to that in 2007-08.

51 The unspent balances accumulated during the initial years allowed for actual spending under NRHM flexipool to exceed 100% in the last two years.
10. The project seeks to remove some of the key constraints facing the UP health sector. The key interventions required to ease these constraints are currently not included in NRHM. Also, the state needs examples of the models that have worked elsewhere along with the operational knowhow of testing those models in the state. From the range of interventions planned for under the project, we pick two interventions which the project will use to try to address these constraints, and analyze their main implications. These interventions are accreditation of public hospitals for improving quality standards, and contracting of laboratory services to private labs.

11. Accreditation of public hospitals: Quality standards set by an independent agency, which in Indian context is the National Board of Accreditation of Hospitals and Healthcare Providers (NABH)\textsuperscript{52} is one approach to improving the performance of health facilities. The UP government is now keen on pursuing the quality agenda in the health sector through accreditation. As of November 2009, seven states have embarked on accreditation of public hospitals, including Andhra Pradesh, Delhi, Gujarat, Kerala, Madhya Pradesh, Tamil Nadu, and Uttar Pradesh. Improvement in quality standards in public hospitals through accreditation is leading to measurable efficiency gains. For example, in one of the public hospitals in Gujarat for which information is available, while the hospital beds increased by only 5% the average daily IPD cases increased by 82%, average daily OPD cases increased by 27% and average lab investigations increased by 30%. Similarly, bed occupancy ratio increased from 77% to 89%, and average length of stay decreased by 25%.\textsuperscript{53} These gains were achieved in a single year between 2006-07 and 2007-08, when accreditation was achieved.

12. The Ram Manohar Lohia Hospital in UP is the first public hospital\textsuperscript{54} in India to have received “provisional accreditation” from NABH. Accreditation of this facility, which

\textsuperscript{52} NABH is a quasi-government agency.
\textsuperscript{53} Source: Quality Assurance Program (NABH Accreditation in Gujarat).
\textsuperscript{54} Private hospital accreditation is common in India.
happened from December 2007 through July 2008, led to significant gains in both efficiency and quality improvement in the hospital as is evident from the tables on efficiency and quality below. The standard efficiency indicators showed improvement after accreditation of RML as shown in Table 1. For example, average number of OPD cases per physician doctor increased by 14% between 2007 and 2009; likewise, over this period, the average number of operations per surgeon increased by 95%, part of which was also due to the increase in the number of beds. It is important to note that prior to accreditation, RML had been operating near its full capacity. The observed increase in these values would not have come about either due to the increase in physical and financial inputs and/or efficiency gains. In RML, the number of physicians has remained constant since 2007 and so the increase in OPD cases would have been mostly due to efficiency gains. 

Table 1: Effect of Accreditation on Selected Efficiency Indicators

<table>
<thead>
<tr>
<th></th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>OPD attendance*</td>
<td>44481</td>
<td>611759</td>
<td>662993</td>
<td>768025</td>
<td>742200</td>
<td>769109</td>
</tr>
<tr>
<td>No. of doctors attending OPD</td>
<td>47</td>
<td>57</td>
<td>66</td>
<td>65</td>
<td>65</td>
<td>65</td>
</tr>
<tr>
<td>Average no. of OPD cases per doctor</td>
<td>9464</td>
<td>10733</td>
<td>10045</td>
<td>11816</td>
<td>11419</td>
<td>11832</td>
</tr>
<tr>
<td>Number of operations done**</td>
<td>2002</td>
<td>2969</td>
<td>6214</td>
<td>9392</td>
<td>11615</td>
<td>16118</td>
</tr>
<tr>
<td>No. of surgeons</td>
<td>14</td>
<td>18</td>
<td>25</td>
<td>24</td>
<td>24</td>
<td>24</td>
</tr>
<tr>
<td>Average no. of operations per surgeon</td>
<td>165</td>
<td>249</td>
<td>391</td>
<td>484</td>
<td>672</td>
<td></td>
</tr>
<tr>
<td>Total no. of beds</td>
<td></td>
<td></td>
<td>225</td>
<td>269</td>
<td>395</td>
<td>395</td>
</tr>
<tr>
<td>Bed Occupancy Rate#</td>
<td></td>
<td></td>
<td>81.7</td>
<td>99.7</td>
<td>91.1</td>
<td>96.4</td>
</tr>
<tr>
<td>Average length of stay (in days)</td>
<td>10.0</td>
<td>9.0</td>
<td>7.3</td>
<td>5.5</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* includes both new and repeat OPD cases

** includes both major and minor operations

# figure for 2008 is erroneous due to counting of both mother and child during institutional deliveries

Source: Based on the data furnished by RML Hospital

13. Accreditation also had a significant effect on service quality as shown in Table 2 below. All the selected quality indicators below show significant improvement in 2009 – the first year post-accreditation.

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55 A more robust analysis would require a refined data set that would permit, for example, analysis of number of OPD cases per physician hour.
Table 2: Effect of Accreditation on Selected Quality Indicators

<table>
<thead>
<tr>
<th></th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of medication errors</td>
<td>4.8</td>
<td>4.5</td>
<td>2</td>
<td>1.1</td>
</tr>
<tr>
<td>Percentage of transfusion reaction</td>
<td>2.9</td>
<td>2.5</td>
<td>1.5</td>
<td>0.3</td>
</tr>
<tr>
<td>Surgical site infection rate</td>
<td>17.2</td>
<td>15.9</td>
<td>8.4</td>
<td>8.7</td>
</tr>
<tr>
<td>Incidence of needle stick injuries</td>
<td>5</td>
<td>4.1</td>
<td>2.9</td>
<td>0.9</td>
</tr>
<tr>
<td>Anaesthetic mishap rates</td>
<td>0.9</td>
<td>0.8</td>
<td>0.5</td>
<td>0.4</td>
</tr>
<tr>
<td>Percentage of bags having properly segregated wastes</td>
<td>75</td>
<td>78</td>
<td>88</td>
<td>97.8</td>
</tr>
</tbody>
</table>

Source: Based on the data furnished by RML Hospital

14. Encouraged by the results of accreditation of RML the GOUP is now aiming to get all public facilities accredited with NABH. In assessing the economic rationale for this investment, there are two types of direct costs involved in getting a health facility accredited: (a) cost of the accreditation process itself which includes cost of hiring consultants to review the gaps, handhold the facility in filling those gaps and so forth, and (b) cost of complying with the requirements of accreditation which includes cost of gap filling, both in infrastructure and processes.

15. The direct benefits of accreditation are: (a) higher staff productivity resulting in higher OPD attendance and higher bed utilization, (b) reduced infection rates and therefore reduced re-admission rates, and (c) greater patient satisfaction.

16. Although the information maintained by RML does not permit rigorous cost-benefit analysis of their accreditation program, a look at the accreditation costs incurred by RML suggests that the recurring cost of accreditation was small in relation to the overall hospital budget (less than 6% of hospital budget for recurring expenses), with the exception of one major gap in the physical infrastructure (that is, cost of air-conditioning). Most of the gaps were in defining processes and protocols and in sensitization and training of staff in the adoption of the same; filling of these gaps does not demand huge financial resources.

17. The experience of RML hospital also indicates that there are indirect costs and benefits associated with the accreditation. On the benefit side, accreditation led to seeking prior written consent of patients or their guardians that protected its medical staff during the legal hearings in medico-legal cases which are routine in the public health care sector. On the costs side, accreditation is invariably associated with strengthening of facility in terms of human resources. Given that human resources in health care is in short-supply in UP and the difficulties in hiring and paying competitive salaries, strengthening of facilities going for accreditation may come at the expense of weakening some other facilities. The presence of this indirect cost is not so much a case against accreditation but a case for making a careful selection of facilities to be accredited and the most efficient use of the human resources available in the public sector.
18. The project plans to support accreditation of 40 facilities in different regions and plans to expand further depending on the success in accreditation process. These facilities have been selected based on (minimum) additional resource requirement of facilities, likelihood of sustainability of accreditation once it is achieved (accreditation is not just a onetime exercise but is to be maintained on an ongoing basis), top-down criteria (higher facilities to be accredited before lower level facilities), and equity considerations (including prioritizing exclusive female hospitals).

19. Benefit-incidence analysis studies in India have shown that the richer sections of the population benefit disproportionately more than the poorer sections from government subsidies going to the health sector (Mahal et al. 2002). Not only do the poor get marginalized in public health facilities, but they often do not get the same quality of care as the rich do. The accreditation of health facilities should benefit the poor as the quality improvements that come with accreditation require defining standard operating procedures that help in adopting uniform policy right from the entry of patients in the hospital through discharge/referral and follow-up by all service providers at the hospital. This would ensure that the quality of care remains the same irrespective of the socio-economic background of the patients. In fact, equity, patient-centeredness, and timeliness of care are among the six important dimensions of quality improvements that come with accreditation.

20. The government estimates that the cost of accrediting 40 facilities (at the rate of US$0.78 million per facility) would be US$31.2 million, part of which (especially on the civil works) will be financed by the government from domestic sources. Assuming the accreditation of 40 facilities to be spread over three years, the annual cost of US$10.4 million would constitute only a small part (0.53%) of the annual health budget of US$2 billion.

21. **Laboratory Services**: Laboratory services in public hospitals in UP are either non-existent or poor. A large facility survey covering 78 district hospitals and 145 CHCs in UP reported that only 9 percent of district hospitals and 2.8 percent of CHCs had the facility to conduct basic blood and urine tests. Diagnostics, which includes laboratory services, account for a significant part of out-of-pocket (OOP) expenditure in public health facilities in UP. As per India’s national health accounts (2004-05), diagnostics account for 14% and 15.4% of OOP expenditure in public facilities in rural and urban areas of UP respectively. One of the project interventions deal with improving availability of, and accessibility to, laboratory services with the view to improve quality of treatment as well as to reduce financial burden associated with it. Additionally, lack of availability of and accessibility to laboratory services may be one of the reasons behind substantially low hospitalization rates observed in UP in comparison to national average. For every 1000 population only 15 persons got hospitalized cases in UP as

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56 With the easing of HRH constraint for which the state is taking actions, the state will be able to move in the direction of achieving accreditation of all the remaining public health facilities using domestic resources.


58 The other three dimensions deal with the issues of safety, effectiveness and efficiency.

59 USAID Report on Rapid Assessment of the Functionality of FRUs and 24x7 PHCs in Uttar Pradesh prepared by Constella Futures, New Delhi May 2008.

60 National Health Accounts for India (2004-05). Ministry of Health and Family Welfare, Government of India
compared to the national average of 25\textsuperscript{61}, suggesting that many people forgo treatment in the state for variety of reasons, one of which may be availability of and accessibility to services, including diagnostics and laboratory services.

22. The project plans to support outsourcing of laboratory services in all the 40 facilities that will be accredited under the project. In addition, outsourcing of laboratory services will also be strengthened more widely to other facilities in different divisions. The number of hospitals enrolled in the laboratory service contracts will be identified after a detailed feasibility survey to determine the availability of quality laboratory service providers in the region, geographical parity to include all accredited facilities and such areas where these services are deemed necessary. Laboratory services will be provided using outsourcing contracts wherein the private player will not only make investments in the required infrastructure but also operate these services. It will be a pure service contract with the private party and therefore no major capital investments are planned for improving laboratory services under the project. These services will be available free of cost to the population below poverty line and for those above the poverty line government will negotiate discounted rates (significantly lower than the market rates) owing to provision of volume guarantee.

23. The outsourcing experience of RML suggests that the extent of discounts available on various laboratory services range between 12.5% and 40% of the market prices (see Table 3 below). However, the potential for discounts is believed to be even greater than indicated below if the volumes (the number of tests) are higher. Note that the RML volumes have been lower because they are not actively promoting it for the simple reason that, in the absence of any government policy for the same, RML is keeping the contracting low key and are funding from their own budget.

<table>
<thead>
<tr>
<th>Tests</th>
<th>Agreed price in INR</th>
<th>No. of tests</th>
<th>Market price in INR</th>
<th>Agreed price as % of market price</th>
<th>Discounts on agreed price</th>
</tr>
</thead>
<tbody>
<tr>
<td>Histopathology (Large)</td>
<td>500</td>
<td>172</td>
<td>650</td>
<td>76.9</td>
<td>23.1</td>
</tr>
<tr>
<td>Histopathology (Small)</td>
<td>350</td>
<td>203</td>
<td>400</td>
<td>87.5</td>
<td>12.5</td>
</tr>
<tr>
<td>Histopathology (Above 2 container)</td>
<td>800</td>
<td>5</td>
<td>1200</td>
<td>66.7</td>
<td>33.3</td>
</tr>
<tr>
<td>T3, T4, T5H Tests</td>
<td>300</td>
<td>77</td>
<td>500</td>
<td>60.0</td>
<td>40.0</td>
</tr>
<tr>
<td>Urine &amp; Pus culture sensitivity</td>
<td>150</td>
<td>31</td>
<td>200</td>
<td>75.0</td>
<td>25.0</td>
</tr>
<tr>
<td>Other test &amp; hormones</td>
<td>-</td>
<td>21</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
</tbody>
</table>

Source: Based on the data furnished by RML Hospital

\textsuperscript{61} As per NSSO 60\textsuperscript{th} Round, for every 1000 population in the state 13 in rural areas and 20 in urban areas got hospitalized in 2005 while the same for the nation as a whole was 23 and 31 respectively. With the urbanization rate of 21% in the state and 28% for India as per census 2001, the hospitalization rate comes to around 1.5% in UP and 2.5% in India.
24. Furthermore, in public hospitals in UP, while medicines are free for all the patients, diagnostic services are free only for the BPL population. The figures for BPL patients are not readily available with RML but the information that RML could furnish was on the BPL beneficiaries of X-Rays and ultra sounds performed by RML. About 35-40% of total X-Rays and 60% of the total ultrasounds done at RML were for the BPL patients. If the figures are used as proxies for the BPL patients at RML, then the BPL patients do constitute substantial beneficiaries of these services. The project support to contracting of laboratory services in the public health facilities will contribute to better treatment as well as reduce out-of-pocket spending for health. The outsourcing experience under the project will also guide the state in devising a policy on contracting in the health sector.

25. To conclude, given that the focus of the project is on strengthening stewardship, policy making and priority setting and improving public sector management functions that complement the investments under NRHM, the Bank project will leverage public investments going into the health sector. The reforms envisaged in the project, if accomplished, are likely to be game changing and will have a lasting impact for the direction of healthcare delivery in the state.

FINANCIAL ANALYSIS

26. Public health care financing in the state has been rising in the last few years, touching US$1.7 billion (up from US$0.74 billion in 2005-06) or about US$9 per-capita in 2009-10 (from US$4 per-capita in 2005-06). This was budgeted to increase to US$2 billion or about US$10 per-capita in 2010-11. Even though as a share of its gross state domestic product, public health spending in UP is (1.6%) higher than the national average (of about 1%) due to relatively small size of its economy, its per-capita public health spending is not greater than the national average. Also, the state’s share of public health spending in GSDP has been exhibiting a rising trend (see the graph 1 below).

Graph 2: Share of public health spending in Gross State Domestic Product

[Graph showing the share of public health spending in GSDP from 2002-03 to 2009-10 with two lines: Total public health spending and State's own public health spending.]

62 As stated earlier in the PAD, the per-capita income of the state, which is one of the indicators of the size of the economy, is substantially below the national average.
27. Total public health spending in the state has shown a significant increase, particularly post-NRHM, rising about 135% (in nominal terms) between 2005-06 and 2009-10. This increase is on account of increasing contribution by the state through its own budget (rising by about 97% over this period) as well as on account of the central assistance that has been playing an increasing role, contributing anywhere between 25% and 30% of the total public health financing. Furthermore, increase in public health spending in UP is also part financed by the special health grants by the twelth finance commission that made such grants between 2005 and 2010 to the 7 weaker states, of which UP was one.

28. Central assistance is primarily routed through the NRHM channel. Much of financial assistance under NRHM bypasses state treasury and goes directly to individual accounts of district health societies but some part of NRHM funds particularly under “family health” continues to flow through the treasury (budgetary) route.

29. Although NRHM is a new program, not all the activities that NRHM finances are new. National disease control programs as well as infrastructure maintenance program existed even prior to NRHM but the two flexi-pools, namely NRHM flexi-pool and the RCH flexi-pool have been new and to that extent NRHM financing is additional. The combined share of these two flexi-pools was around 30% of the total NRHM expenditure in the state in 2005-06 but it steadily increased to nearly 75% in 2009-10, suggesting increasing additional NRHM financing for the new set of activities such as untied grants that could be used by health facilities based on their local needs.

30. In the state health budget of 2006-07, the share of primary, secondary and tertiary care was 47.2%, 30.4%, and 22.4% respectively (Chaudhuri 2007). In the subsequent years of NRHM implementation, this share moved in favor of primary and, to some extent secondary care, at the expense of tertiary care.63

31. UP faced challenges in absorbing NRHM resources in the initial years as was the case in other weaker states. Accordingly, utilization of NRHM resources, though improving with time, remained lower than the NRHM allocations for all the years except 2008-09 when utilization exceeded allocations which to some extent was due to the fact of allocations remaining the same (constant) as that in the previous year. The graph below shows the utilization of NRHM resources (Y-axis denotes INR Billion).

63 The National Health Policy of 2002 sets the target share of primary, secondary and tertiary care in total public health investments to be 55%, 35% and 10% respectively.
32. The cost of the project is US$170 million (or INR 7650 million)\textsuperscript{64} of which the Bank finances about 90%, i.e., US$152 million. The Bank’s assistance would constitute 7.6% of the budgeted amount of US$2 billion for 2010-11. Since the Bank’s contribution is spread over a five year period, the annual Bank contribution will on average be around 1.5% of the public health financing.\textsuperscript{65} The Bank through its project is expected to leverage its resources to strengthen stewardship role of the government in the health sector, to expand the capacity and improve efficiency of the health system – all of this should enhance effectiveness of total public investments going into the health sector. Given the small size of project investments relative to the overall size of health budget, sustaining the project activities financially beyond the life of the project should not pose any problem if such activities prove successful.

\textsuperscript{64} US$1= INR 45.

\textsuperscript{65} In fact, this percentage will get reduced as the government budget increases during the project period.